

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and leg-

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frances Clarkson

2. DATE  
OF  
DEATH

4/11/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

220 Bradford St N.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

Female

Col.

Widow

11/5/1890

59

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William Henry Simms

14. MOTHER'S MAIDEN NAME

Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Clarkson 220 Bradford St

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

CAUSE OF DEATH

(A) Pulmonary edema

(B) Cerebral apoplexy

(C) Hypertension

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

3 days

?

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 9, 1950, to Apr. 11, 1950 that I last saw the deceased alive on Apr. 11, 1950 and that death occurred at 3:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Wm. L. Berry

M. D.

1420 E. Chase

Apr. 15, 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/15/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn A.A.Co.Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

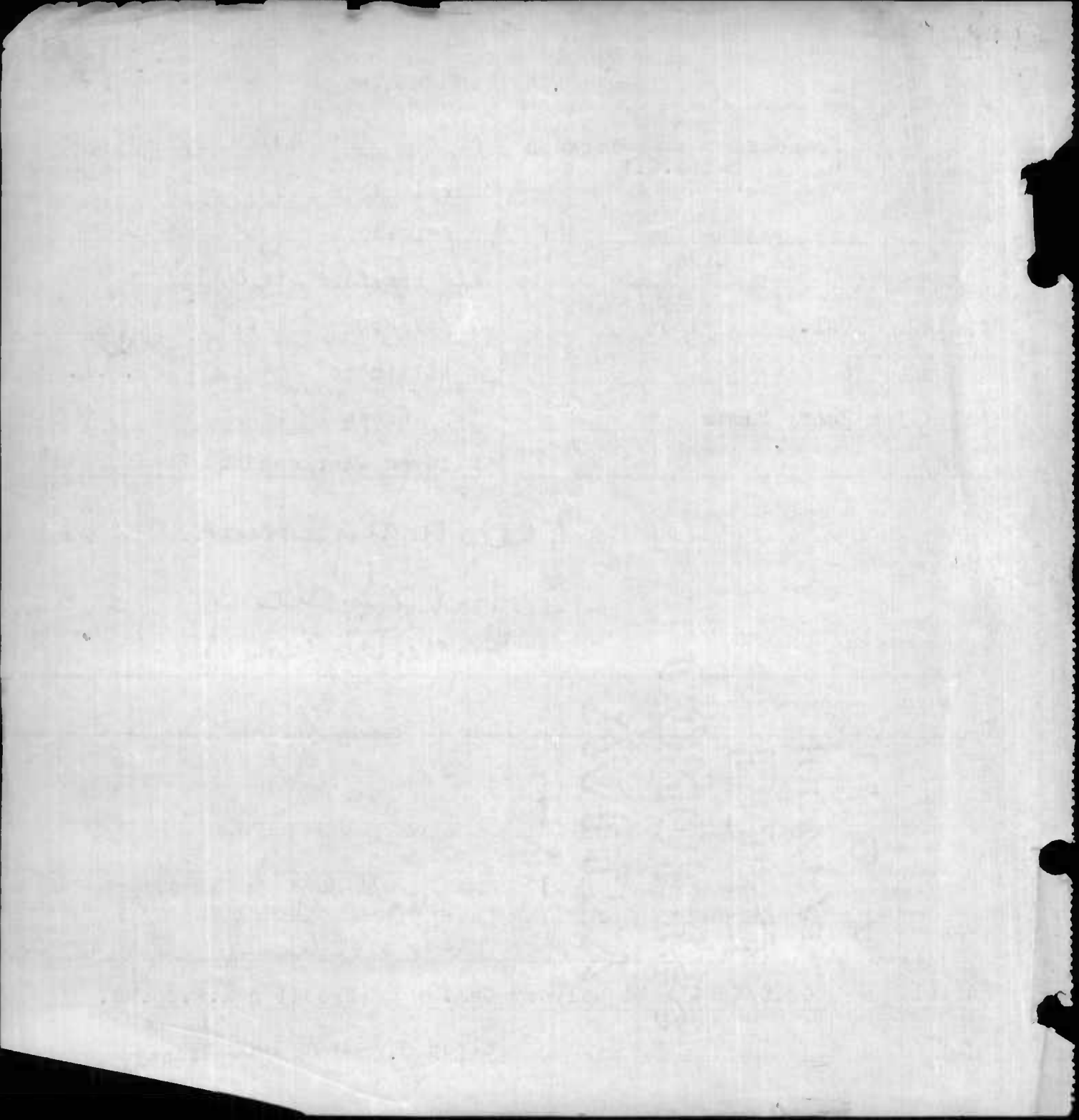
APR 15 1950

William L. Berry

Elroy O. Wilson 1000 Br

VS 150

3501





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3502  
Registered No. \_\_\_\_\_

BIRTH NO. 50 3502

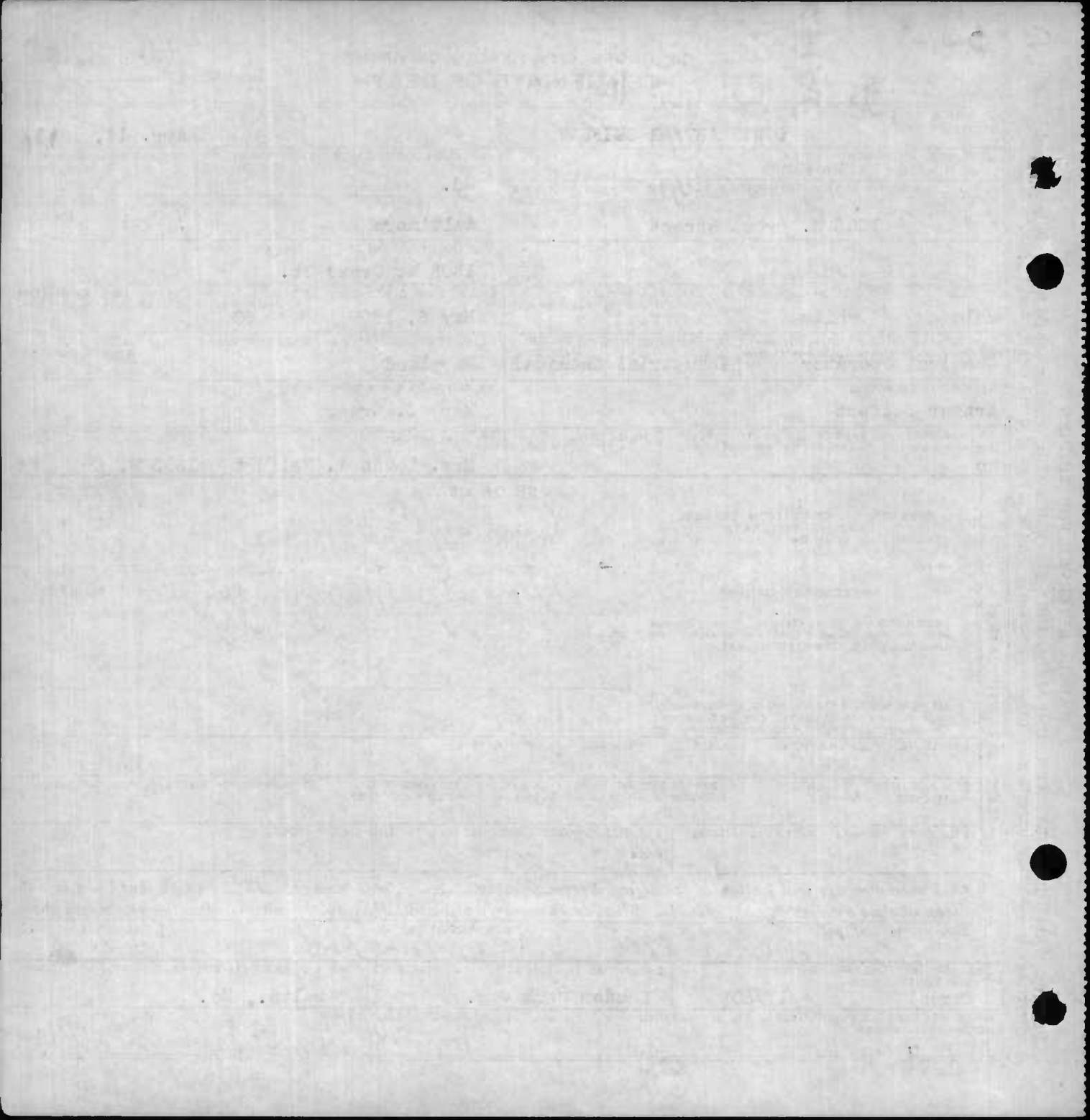
1. NAME OF DECEASED (Type or Print) <b>LOUIS ARTHUR SEIFERT</b>			2. DATE OF DEATH <b>Apr. 14, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1305 W. Cross Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>21-02</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>1305 W. Cross St.</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 6, 1899</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemical Operator</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Industrial Chemical</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME <b>Arthur Seifert</b>			14. MOTHER'S MAIDEN NAME <b>Mary J. Greer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <b>Mrs. Louis A. Seifert</b>		
			ADDRESS <b>1305 W. Cross St</b>		

MEDICAL CERTIFICATION	18. <b>002 X</b>	CAUSE OF DEATH <b>Coronary Occlusion</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5-10 min.</b>
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) _____</b>		DUE TO <b>Advanced pulmonary tuberculosis left</b>
	DUE TO <b>(B) _____</b>		
	DUE TO <b>(C) _____</b>		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>Jan 15</b> , 19 <b>50</b> , to <b>April 14</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>April 14</b> , 19 <b>50</b> , and that death occurred at <b>12:00 noon</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Aug E M.D.</b>		23B. ADDRESS <b>6422 Wash. Blvd</b>		23C. DATE SIGNED <b>4-15-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/17/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 15 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams</b>		25. FUNERAL DIRECTOR <b>Wm. J. Pickens &amp; Sons - Balto Md.</b>	
VS 150		496 97		130	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3503

BIRTH NO. 3503

1. NAME OF DECEASED (Type of name) <i>Marian M. Knight</i>			2. DATE OF DEATH <i>April 14 - 1950</i>		
3. PLACE OF DEATH: a. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>Md.</i>		
b. FULL NAME OF (If not in hospital or institution, give street address or location) <i>810 W. 36<sup>th</sup> St.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>13-07</i>		
d. Length of stay in Baltimore <i>Life</i>			e. STREET ADDRESS (If rural, give location) <i>810 W 36<sup>th</sup> St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Nov 22 - 1875</i>		9. AGE (In years last birthday) <i>74</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if specified) <i>Retired School Teacher</i>			11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Md.</i>
13. FATHER'S NAME <i>Joseph R. Knight</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Vandon</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or not known) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>none</i>		
17. INFORMANT <i>Mar. L. Knight</i>			ADDRESS <i>810 W 36<sup>th</sup> St.</i>		

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs.</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Coronary Intery Dis.</i> DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Apr 13, 1950</i> , to <i>Apr 14, 1950</i> , that I last saw the deceased alive on <i>Apr 13, 1950</i> and that death occurred at <i>2:04</i> m., from the causes and on the date stated above.					
23a. SIGNATURE <i>Edward L. Gassman</i> M.D.		23b. ADDRESS <i>4037 E. Falls Rd.</i>		23c. DATE SIGNED <i>4/14/50</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>Apr. 17-1950</i>		24c. NAME OF CEMETERY OR CREMATORY <i>St. Marys Hampton</i>	
24d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>		25. FUNERAL DIRECTOR <i>Sham Shultz</i>		ADDRESS <i>810 W 36<sup>th</sup> St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 15 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Williams, Jr.</i>			

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that \_\_\_\_\_ of the County of \_\_\_\_\_ State of \_\_\_\_\_ do hereby certify that \_\_\_\_\_ was born on \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_ Texas.

He is now \_\_\_\_\_ years of age, and is a resident of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

He is a \_\_\_\_\_ of the \_\_\_\_\_ of \_\_\_\_\_ Texas.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3504  
Registered No.

D120

50 3504

BIRTH NO.		50 3504	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Marry Emma Davis		April 15-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 3848 Guilford Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
D. STREET ADDRESS (If rural, give location)		2848 Guilford Ave	
c. Length of stay in Baltimore 3 yrs 6 mos		8. DATE OF BIRTH	
5. SEX Female		9. AGE (In years last birthday) 78 yrs	
6. COLOR OR RACE white		11. BIRTHPLACE (State or foreign country)	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Benjamin Garrett		14. MOTHER'S MAIDEN NAME AMANDA NELSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknowns) (If yes, give war or dates of service)		17. INFORMANT ADDRESS	
16. SOCIAL SECURITY NO.		The May Bonney 2848 Guilford Ave	
18. 4221 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
DUE TO		Atherosclerotic Cardiovascular disease 3 yrs	
ANTECEDENT CAUSES		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pernicious Anemia 4 yrs	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1, 1948 to April 15, 1950, that I last saw the deceased alive on April 4, 1950 and that death occurred at 5:30 a.m., from the causes and on the date stated above.			
23A. SIGNATURE Lloyd E. Saylor		23B. ADDRESS 3902 Greenmount Ave.	
23C. DATE SIGNED April 15, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE April 17-1950	
24C. NAME OF CEMETERY OR CREMATORY West Liberty		24D. LOCATION (City, town, or county) (State) Md	
DATE RECEIVED BY LOCAL REGISTRAR APR 16 1950		REGISTRAR'S SIGNATURE Howard S. Markline	
25. FUNERAL DIRECTOR		ADDRESS White Hall Rd	

93D

DEPARTMENT OF HEALTH  
STATE OF CALIFORNIA  
BUREAU OF VETERINARY MEDICINE  
DIVISION OF ANIMAL INDUSTRY  
OFFICE OF THE VETERINARIAN IN CHARGE  
SAN FRANCISCO, CALIFORNIA

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W 436  
50 3505

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3505  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ruth Walters

2. DATE  
OF  
DEATH

APR 15 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Surg - Thayer 1

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

Somerset

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Crisfield

6932

D. STREET ADDRESS (If rural, give location)

231 Sommer set Ave.

c. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7-28-99

9. AGE (In years last birthday)

50

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

584X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) lower nephron nephrosis -

DUE TO

2 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pneumonia & peritonitis

DUE TO

2 wks

(C) Cholelithiasis  
Common duct obstruction

DUE TO

6 mo

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3/30/50

19B. MAJOR FINDINGS OF OPERATION

Common duct obstruction

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-28-1950 to 4-15-1950, that I last saw the deceased alive on 4-15-1950, and that death occurred at 5:50 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Quane T. Minnell M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/15/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

4/18/50

24C. NAME OF CEMETERY OR CREMATORY

Crisfield

24D. LOCATION (City, town, or county)

Crisfield Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Walter J. Bradshaw

531 Main St., Crisfield, Md.

APR 16 1950

531 Main St., Crisfield, Md.  
126

4/15/50  
~~CONFIDENTIAL~~  
CONFIDENTIAL  
CONFIDENTIAL  
CONFIDENTIAL

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3506

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)JOSEPHINE JONES2. DATE  
OF  
DEATH4-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Mercy Hospital Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Washington D.C.B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONMercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington D.C. V-48

D. STREET ADDRESS (If rural, give location)

1651 Newton St

c. Length of stay in Baltimore

2 Yrs.  
— Mos.  
— Days

5. SEX

F.

6. COLOR OR RACE

White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Widow

8. DATE OF BIRTH

18669. AGE (In years  
last birthday)8410 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)House10B. KIND OF BUSINESS OR  
INDUSTRYn

11. BIRTHPLACE (State or foreign country)

Washington DC12. CITIZEN OF  
WHAT COUNTRY?U.S.A

13. FATHER'S NAME

David McCalliffe

14. MOTHER'S MAIDEN NAME

Ellen Donahoe15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or dates of service)No16. SOCIAL  
SECURITY NO.

17. INFORMANT

J. D. Nelson

ADDRESS

Washington 10.0a.

18.

153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Carcinoma large Bowel22 days

DUE TO

ANTECEDENT CAUSES

(B)

Vascular Disease

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3-25-50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Large Bowel

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-18-50, 19—, to 4-16-50, 19—, that I last saw the  
deceased alive on 4-16-50, 19—, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

C. F. Bailey

23B. ADDRESS

Mercy Hosp

23C. DATE SIGNED

4-16-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/16/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Washington D.C.DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Fischer & Son Mt. Pa. ave.

APR 16 1950

46E

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Age at Death	
Sex		Race	
Marital Status		Cause of Death	
Occupation		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Time of Death	
Signature of Coroner		Signature of Medical Examiner	
Signature of Burial Officer		Signature of Undertaker	
Signature of Funeral Home		Signature of Cemetery	
Signature of Church		Signature of Minister	
Signature of Family		Signature of Friends	
Signature of Neighbors		Signature of Community	
Signature of City		Signature of State	
Signature of Country		Signature of World	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3507BIRTH NO. 50 35071. NAME OF DECEASED  
(Type or Print)

Robert Purvis McGuinn

2. DATE  
OF  
DEATH

April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION US Marine Hospital,  
Baltimore, Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore

township)

c. Length of stay in Baltimore

----

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2030 McCullough Street

5. SEX

male

6. COLOR OR RACE

col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 14, 1898

9. AGE (In years  
last birthday)

51

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Attorney at Law

10B. KIND OF BUSINESS OR  
INDUSTRY

Attorney at Law

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert McGuinn

14. MOTHER'S MAIDEN NAME

Nannie Servant

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL  
SECURITY NO.

--

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto., Md.

18.

151 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

8 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST,

(B) Obstruction of Common Bile Duct

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 12, 1950 to Apr. 15, 1950, that I last saw the  
deceased alive on Apr. 15, 1950, and that death occurred at 4:05 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Norman Tarr

M. D.

23B. ADDRESS

US Marine Hospital, Balto., Md. 4/15/1950

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

April 19, 1950

Arbutus Mem. Park

Baltimore Ci. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

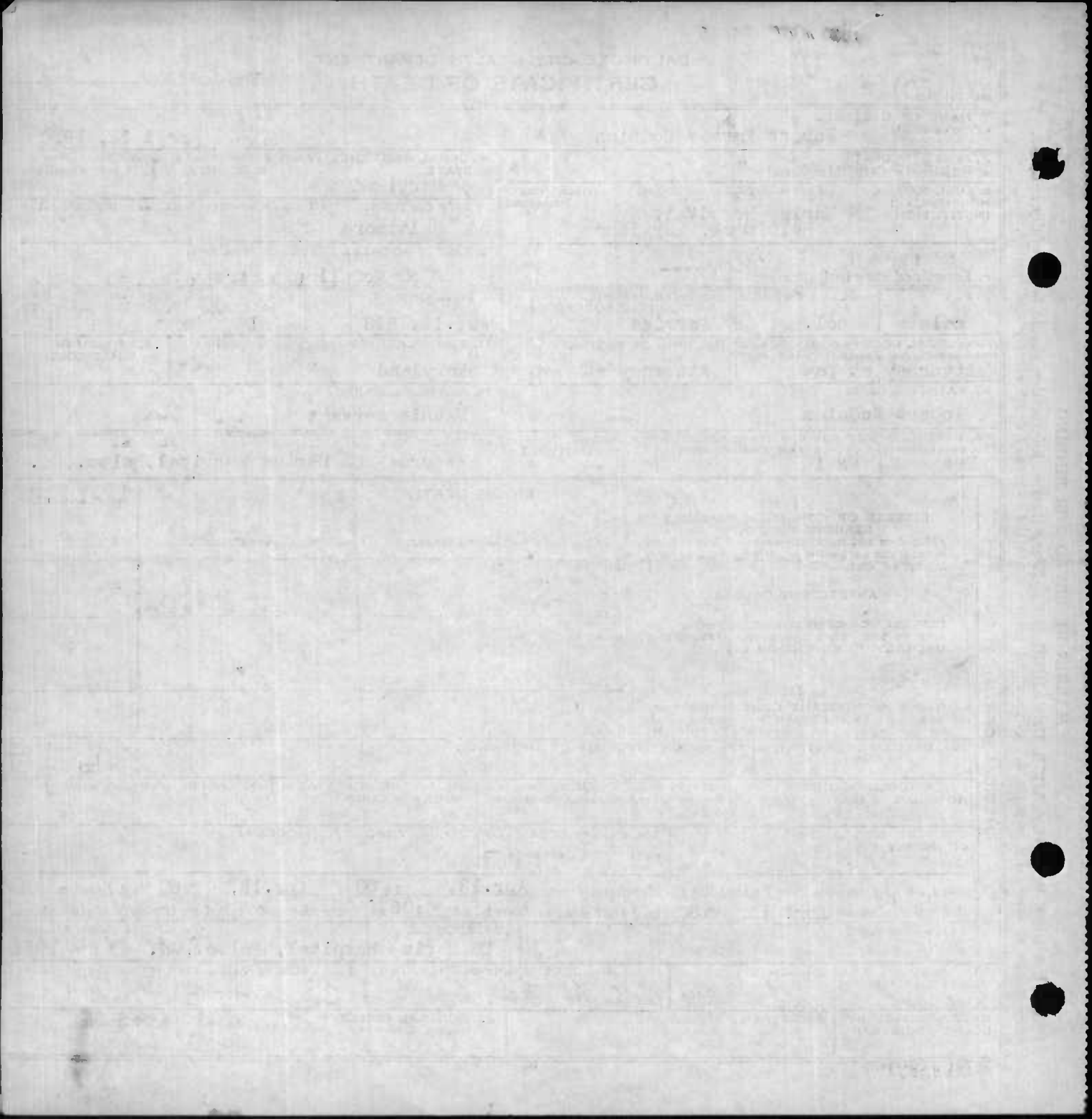
APR 19 1950

[Signature]

[Signature]

1631 David Hill Ave.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3508

BIRTH NO. 50 3508

1. NAME OF DECEASED  
(Type or Print)

*Sarah Norman*

2. DATE  
OF  
DEATH

*April 14, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*00 2436 Brentwood Ave.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 12-00*

D. STREET ADDRESS (If rural, give location)

*2436 Brentwood Ave*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Single*

8. DATE OF BIRTH

*Nov 28, 1870*

9. AGE (In years last birthday)

*80*

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housekeeper*

10B. KIND OF BUSINESS OR INDUSTRY

*At home*

11. BIRTHPLACE (State or foreign country)

*Chester town, Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*David Norman*

14. MOTHER'S MAIDEN NAME

*Francis Madison*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No.*

16. SOCIAL SECURITY NO.

*None*

17. INFORMANT

*Miss Lucie Norman*

ADDRESS

*2436 Brentwood Ave*

18. *442X*

I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

*Cerebral Disease*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*Asthenia - Sclerosis*

(C)

INTERVAL BETWEEN ONSET AND DEATH

*1 Yr.*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *April 10, 1950*, to *April 14, 1950*, that I last saw the deceased alive on *April 13, 1950*, and that death occurred at *4 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Eric C. Steen*

23B. ADDRESS

*2329 Gough St. S.E.*

23C. DATE SIGNED

*April 14-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*4/16/1950*

24C. NAME OF CEMETERY OR CREMATORY

*Wm. Zion*

24D. LOCATION (City, town, or county)

*Baltimore Co. Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

*Holland*

ADDRESS

*Funeral Home*

*APR 16 1950*

*131a*

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF MINISTER

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF CHURCH

17. SIGNATURE OF PARISH

18. SIGNATURE OF DISTRICT

19. SIGNATURE OF COUNTY

20. SIGNATURE OF STATE

21. SIGNATURE OF NATION

22. SIGNATURE OF WORLD

23. SIGNATURE OF UNIVERSE

24. SIGNATURE OF GOD

25. SIGNATURE OF JESUS

26. SIGNATURE OF HOLY SPIRIT

27. SIGNATURE OF CHURCH

28. SIGNATURE OF PARISH

29. SIGNATURE OF DISTRICT

30. SIGNATURE OF COUNTY

31. SIGNATURE OF STATE

32. SIGNATURE OF NATION

33. SIGNATURE OF WORLD

34. SIGNATURE OF UNIVERSE

35. SIGNATURE OF GOD

36. SIGNATURE OF JESUS

37. SIGNATURE OF HOLY SPIRIT

38. SIGNATURE OF CHURCH

39. SIGNATURE OF PARISH

40. SIGNATURE OF DISTRICT

41. SIGNATURE OF COUNTY

42. SIGNATURE OF STATE

43. SIGNATURE OF NATION

44. SIGNATURE OF WORLD

45. SIGNATURE OF UNIVERSE

46. SIGNATURE OF GOD

47. SIGNATURE OF JESUS

48. SIGNATURE OF HOLY SPIRIT

49. SIGNATURE OF CHURCH

50. SIGNATURE OF PARISH

51. SIGNATURE OF DISTRICT

52. SIGNATURE OF COUNTY

53. SIGNATURE OF STATE

54. SIGNATURE OF NATION

55. SIGNATURE OF WORLD

56. SIGNATURE OF UNIVERSE

57. SIGNATURE OF GOD

58. SIGNATURE OF JESUS

59. SIGNATURE OF HOLY SPIRIT

60. SIGNATURE OF CHURCH

61. SIGNATURE OF PARISH

62. SIGNATURE OF DISTRICT

63. SIGNATURE OF COUNTY

64. SIGNATURE OF STATE

65. SIGNATURE OF NATION

66. SIGNATURE OF WORLD

67. SIGNATURE OF UNIVERSE

68. SIGNATURE OF GOD

69. SIGNATURE OF JESUS

70. SIGNATURE OF HOLY SPIRIT

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3509  
Registered No.F263  
50 3509  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Thomas Fogarty</i>		2. DATE OF DEATH <i>April 14, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <i>1200 Valley Street - 430 S. Gilman St</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Hamer for Aged <i>Little Sisters of the Poor</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>430 S. Gilman St.</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W</i>	8. DATE OF BIRTH <i>69</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Carber</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>W.S.</i>	
13. FATHER'S NAME <i>Joseph Fogarty</i>		14. MOTHER'S MAIDEN NAME <i>Onaquit Meyer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sister Marguerite - 1200 Valley Street</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1B. <i>470 1</i> DUE TO <i>Acute Coronary Thrombosis</i> 1 day		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Arterio-Sclerosis</i> DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 10</i> , 1950, to <i>April 14</i> , 1950, that I last saw the deceased alive on <i>April 13</i> , 1950, and that death occurred at <i>5:45 A.M.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>E. G. Hall Hall M.D.</i>		23B. ADDRESS <i>1631 E North Ave</i>	23C. DATE SIGNED <i>April 14-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Apr. 17, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 16 1950</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <i>Rita Wiedefeld 9006 Biddle St</i>	

OFFICE OF THE ATTORNEY GENERAL  
STATE OF TEXAS

WALTER  
CONGRESS  
BOND  
U. S. S.

M520 50 3510

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3510

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MANNS, John Wesley

2. DATE  
OF  
DEATH

4/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Provident

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

952 Harlem

c. Length of stay in Baltimore

35 yrs.

5. SEX

M

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

2/16/1888

9. AGE (In years last birthday)

61

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stevedore labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Alfred manns

14. MOTHER'S MAIDEN NAME

Emma Curry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary M. Young 635 N. Carey St

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Chronic Glomerulonephritis

DUE TO

ANTECEDENT CAUSES

(B)

Uremia

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/12, 1950 to 4/13, 1950 that I last saw the deceased alive on 4/13, 1950, and that death occurred at 4:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

John H. Holmes M. D.

23B. ADDRESS

Provident

23C. DATE SIGNED

4/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-16-50

24C. NAME OF CEMETERY OR CREMATORY

ANT. Calvary

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. A. Jackson 916 Rema







K422 50 3511

*KOLAKOWSKI*  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3511  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Charles Kolakowski*2. DATE  
OF  
DEATH*APRIL 14, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*2015 FLEET STREET*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*BALTIMORE**2-03*

D. STREET ADDRESS (If rural, give location)

*2015 FLEET STREET*

c. Length of stay in Baltimore

*LIFE*

5. SEX

*MALE*

6. COLOR OR RACE

*WHITE*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*SINGLE*

8. DATE OF BIRTH

*JAN. 28, 1910*

9. AGE (In years last birthday)

*40*# Under 1 Year  
Months: Days# Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*LABORER*

10B. KIND OF BUSINESS OR INDUSTRY

*MOVING*

11. BIRTHPLACE (State or foreign country)

*BALTIMORE, MD.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*ADOLPH KOLAKOWSKI*

14. MOTHER'S MAIDEN NAME

*JOSEPHINE POPIOLEK*15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*STANLEY KOLAKOWSKI, 407 N. LINCOLN AVE*

18.

*420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Coronary Artery Disease*

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Autopsy, Inspection or Inquiry* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Carl L. Royer*23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....23C. DATE SIGNED  
*16 April 50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*BURIAL*

24B. DATE

*4/17/50*

24C. NAME OF CEMETERY OR CREMATORY

*ST. STANISLAUS*

24D. LOCATION (City, town, or county)

*BALTIMORE, MD.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Walter J. Williams*

25. FUNERAL DIRECTOR

*M. F. K. K. K. K. K.*

ADDRESS

*1828 Eastern Avenue*

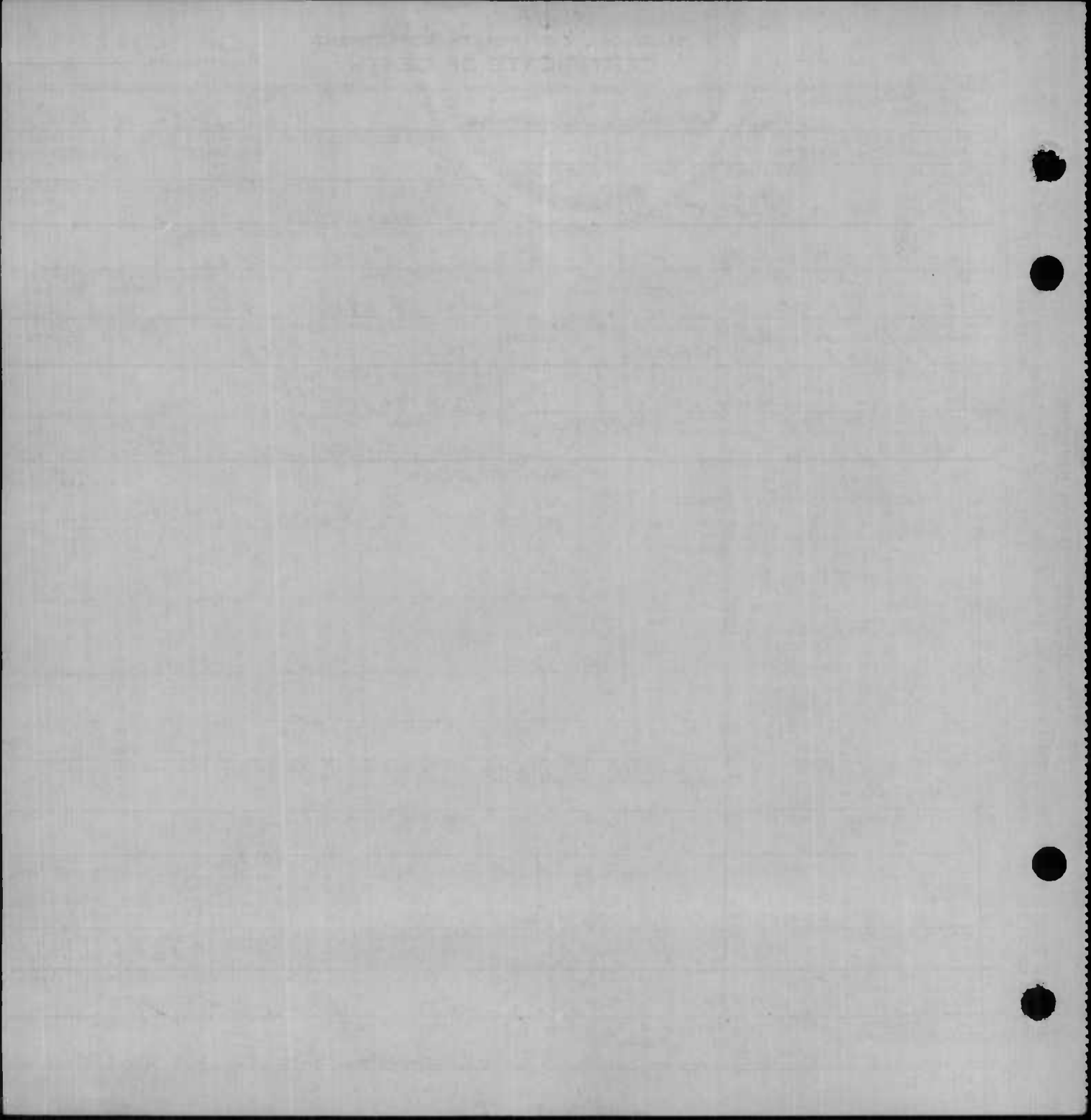
VS 161550

98F50

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



C-400

50 3512

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3512

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Minnie B. Cole

2. DATE  
OF  
DEATH

4/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3520 Hilton St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

528 Orkney Rd

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Dec 25, 1870

9. AGE (In years  
last birthday)

79

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Same

13. FATHER'S NAME

Harry Dickel

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Laura V. LeCompte

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ABRAHAM B. COLE - 528 Orkney Rd

18.

Hypertension

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Antecedent disease - U. S. disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. J. Sullivan

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

4/16/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/18/50

24C. NAME OF CEMETERY OR CREMATORY

Western Cemetery

24D. LOCATION (City, town, or county)

Edmondson Ave

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

William A. Williams

25. FUNERAL DIRECTOR

Chas. C. Towell

ADDRESS

3427

ADDRESS

Edmondson Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The contact age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

STATE OF TEXAS

DEPARTMENT OF HEALTH

1900

1900



B-320

50 3513

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Harry Stuart Bates

2. DATE  
OF  
DEATH

Apr 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Alabama

B. COUNTY

unk

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

U.S. Marine Hospital, Balto., Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Mobile

D. STREET ADDRESS (If rural, give location)

353 Monroe St.

c. Length of stay in Baltimore

30

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/5/01

9. AGE (In years

last birthday)

48

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lt., USCG

10B. KIND OF BUSINESS OR INDUSTRY

Seaman

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Harry Bates

14. MOTHER'S MAIDEN NAME

Harriet Spooner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NKK Yes

#1 + #2

16. SOCIAL SECURITY NO.

570-36-2209

17. INFORMANT

ADDRESS

Medical Records, USMH Balto., Md.

18. 162X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, left lung, with extension to pleura and vertebrae

DUE TO

Unk.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on 4/15, 1950, and that death occurred at 8:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Clyde H. Dabbs

M. D.

23B. ADDRESS

U.S. Marine Hospital, Balto., Md.

23C. DATE SIGNED

Apr 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

April 19-1950

24C. NAME OF CEMETERY OR CREMATORY

Mobile National

24D. LOCATION (City, town, or county)

Mobile Alabama

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

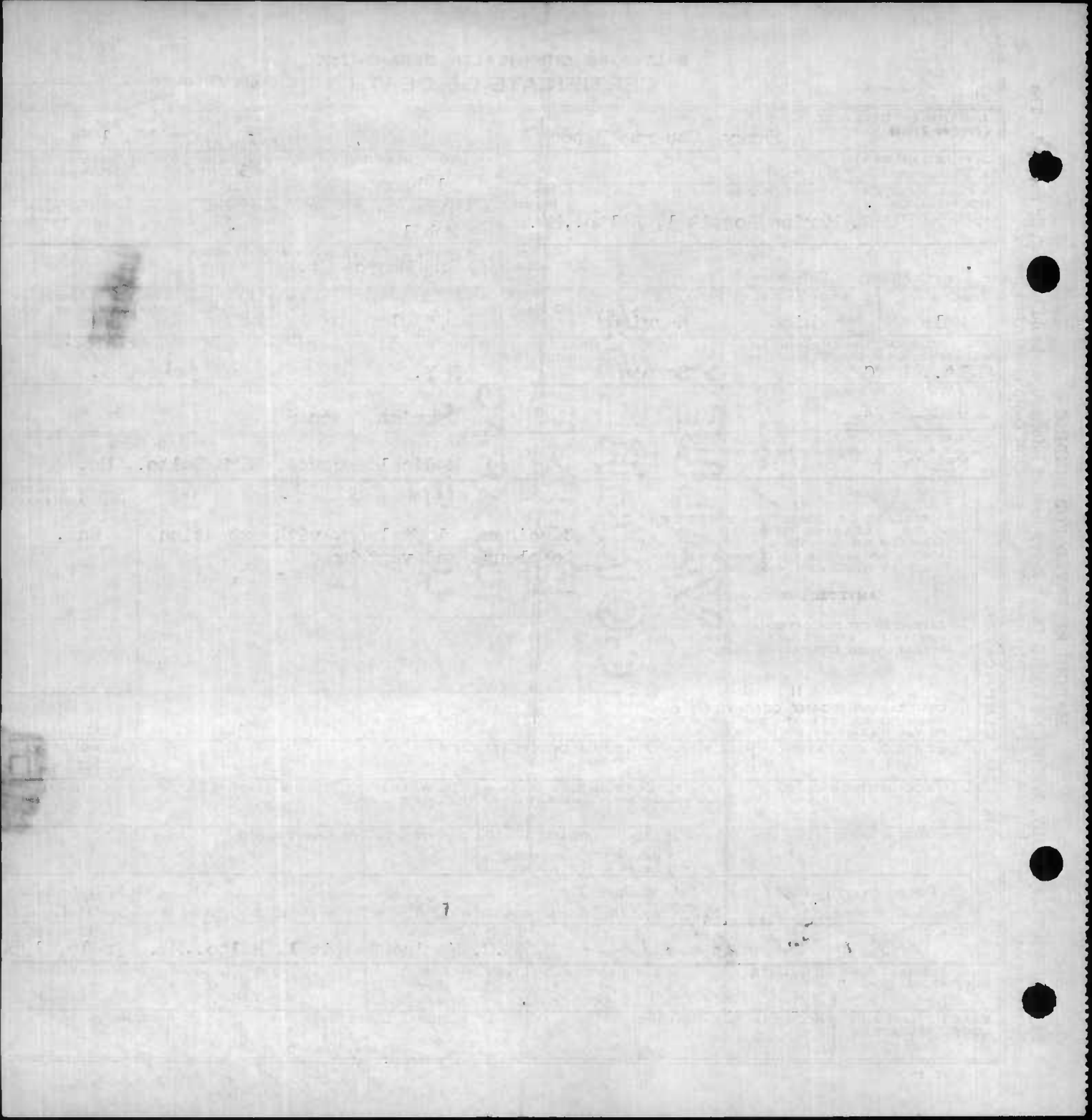
William H. Williams

25. FUNERAL DIRECTOR

H. Glendon &amp; Sons, Inc.

ADDRESS

1649 E. North Ave, 47D





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3514

Registered No. \_\_\_\_\_

50 3514

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Morris Foote</i>			2. DATE OF DEATH <i>April 15, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JONES HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 19-02</i>		
c. Length of stay in Baltimore <i>9</i> Yrs. <i>1732 W. Lexington St.</i>			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3-5-23</i>		9. AGE (In years last birthday) <i>27</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Free Nursing</i>	11. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Eugene Foote</i>			14. MOTHER'S MAIDEN NAME <i>Carey Johnson</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-05-6656</i>	17. INFORMANT <i>JONES HOPKINS HOSPITAL</i> ADDRESS _____		

18. <i>525X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) DUE TO	<i>Chronic Pulmonary fibrosis + cor pulmonale</i>	<i>10 yrs</i>
	(B) DUE TO	<i>Unknown cause</i>	
	(C) DUE TO		

19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-11</i> , 19 <i>50</i> , to <i>4-15</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>4-15</i> , 19 <i>50</i> , and that death occurred at <i>6:55</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>David Rogers</i>		23B. ADDRESS <i>JONES HOPKINS HOSPITAL</i>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Apr. 18 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Basil</i>	
24D. LOCATION (City, town, or county) (State) <i>Cockeysville Md</i>		25. FUNERAL DIRECTOR <i>Louise M. Burtch, Sparks, Md.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 17 1950</i>		REGISTRAR'S SIGNATURE <i>Antington Williams</i>			



CERTIFICATE CORRECTED 4-21-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3515

B-260  
50 3515  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Holmes Davenport Baker</i>			2. DATE OF DEATH <i>4-15-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Frederick</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Frederick 6000</i>		
c. Length of stay in Baltimore Yrs. <i>44</i> Mos. Days			D. STREET ADDRESS (If rural, give location) <i>Waverly Farm - West of Frederick</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 11, 1880</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Banking</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Banking</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Joseph D Baker</i>			14. MOTHER'S MAIDEN NAME <i>Emma Cunningham</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War I</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT ADDRESS <i>Hospital Records</i>		

18. <i>561.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Post-op. Paralytic shock</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Due to</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hypostatic pneumonia</i>					
19A. DATE OF OPERATION <i>April 10, 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>Direct Inguinal Hernia, Left</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office hldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 9, 1950</i> , to <i>April 15, 1950</i> , that I last saw the deceased alive on <i>April 15, 1950</i> , and that death occurred at <i>11:40 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Marshall D. Esrie, Jr.</i>		23B. ADDRESS <i>M.D. Union Memorial Hospital</i>		23C. DATE SIGNED <i>4-16-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4-18-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Frederick - Md.</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 17 1950</i>		REGISTRAR'S SIGNATURE <i>Washington Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>C. E. Clize &amp; Son - Frederick - Md.</i>	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 3516

BIRTH NO. 49-21570

1. NAME OF DECEASED  
(Type or Print)

Janice George

2. DATE  
OF  
DEATH

4/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

33-03

D. STREET ADDRESS (If rural, give location)

1829 S. Charles Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/3

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U S

13. FATHER'S NAME

Ellwood George

14. MOTHER'S MAIDEN NAME

Delores Fitzhugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

ELLWOOD GEORGE 1829 S CHARLES ST

18. 289.0 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GAUCHER'S DISEASE  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)   
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)   
DUE TO

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/24/50, 19  , to 4/13/50, 19  , that I last saw the deceased alive on 4/13/50, 19  , and that death occurred at 11:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Samuel P. Scalia

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

4/13/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-17-50

24C. NAME OF CEMETERY OR CREMATORY

HOLY CROSS CEM.

24D. LOCATION (City, town, or county)

A.A. Co.

(State)

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

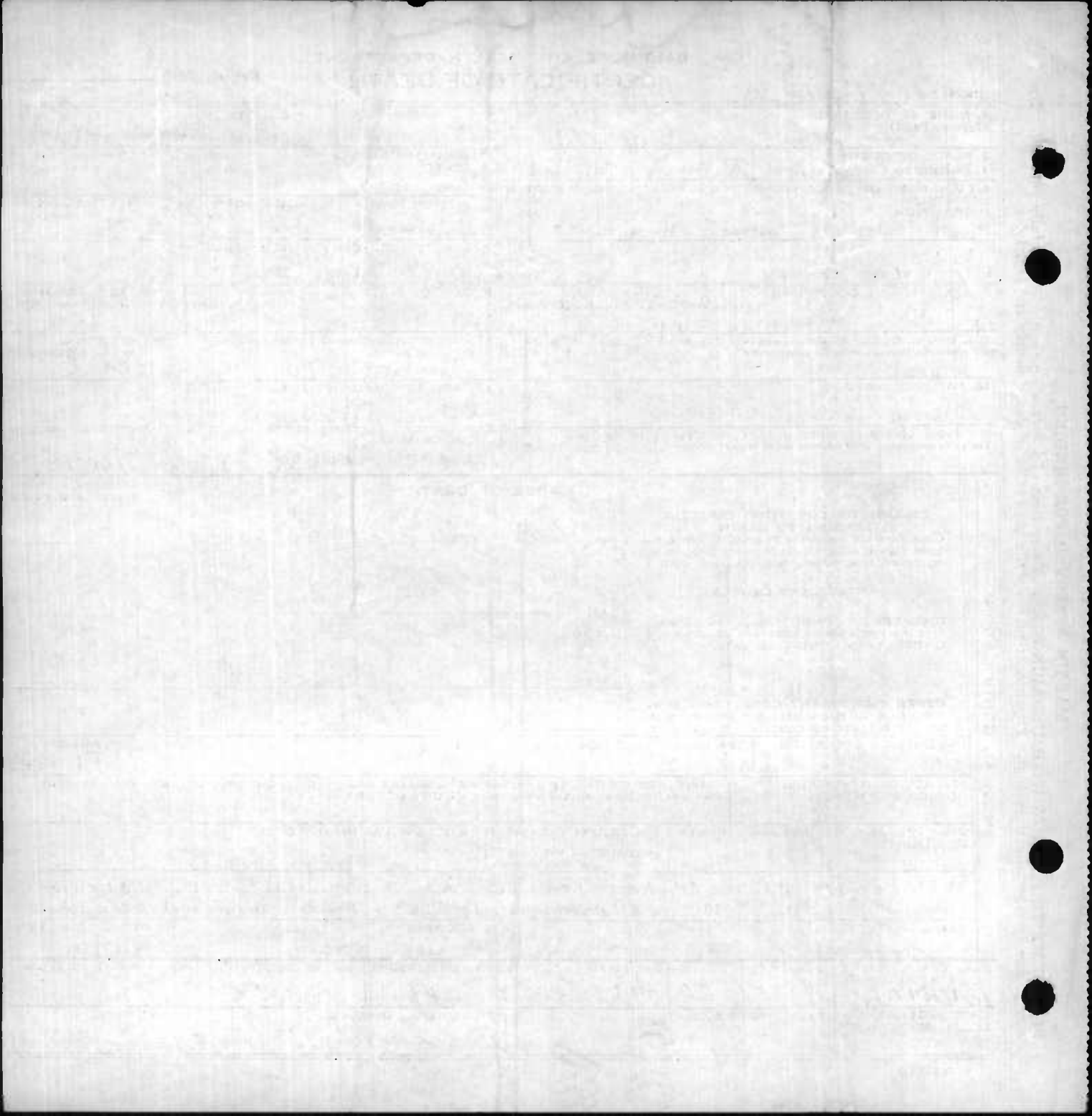
Timothy H. Hill

25. FUNERAL DIRECTOR

ADDRESS

Bernard C. Harle 121 E. West St







J-525-137292

CERTIFICATE CORRECTED 4-19-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3517  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Taylor Johnson

2. DATE  
OF  
DEATH

April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

748 W. Saratoga St.

c. Length of stay in Baltimore

30 yrs.

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

July 14, 1888

9. AGE (In years last birthday)

(66) 01

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records\* 4940 Eastern Ave.

18. 162 X I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-13-1950 to 4-15-1950, that I last saw the deceased alive on 4-15-1950 and that death occurred at 12:25 AM from the causes and on the date stated above.

23A. SIGNATURE

J. S. Cohen M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-18-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

A. A. Co Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

James A. Hayes

ADDRESS

638 N. 9th St

VS 150

98895

47c

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VALLEY

RECEIVED

RECORDS

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

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D-253

De SANDRO

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3518

Registered No.

BIRTH NO. 50 3518 50 - 07875

1. NAME OF DECEASED  
(Type or Print)

Baby

De Sandro

2. DATE  
OF  
DEATH

Apr. 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

40 St Agnes Hospital

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

28-01

D. STREET ADDRESS (If rural, give location)

6700 Reisterstown Rd.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

CLARE De Sandro

18. 756.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

atelectasis &amp; cardiac

DUE TO

fatigue.

1 hr.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Congenital malformation of

DUE TO

diaphragm &amp; formation of

(C)

sternum & cartilages into  
chest cavity.

?

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-14, 1950, to 4-15, 1950, that I last saw the deceased alive on 4-14, 1950, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. W. Sherrin

M. D.

23B. ADDRESS

St Agnes' Hospital

23C. DATE SIGNED

4-15-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/16/50

24C. NAME OF CEMETERY OR CREMATORY

Saver's Park

24D. LOCATION (City, town, or county)

German Hill Rd

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

J. J. Tully, 1318 Light

VS 150

157M

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3519

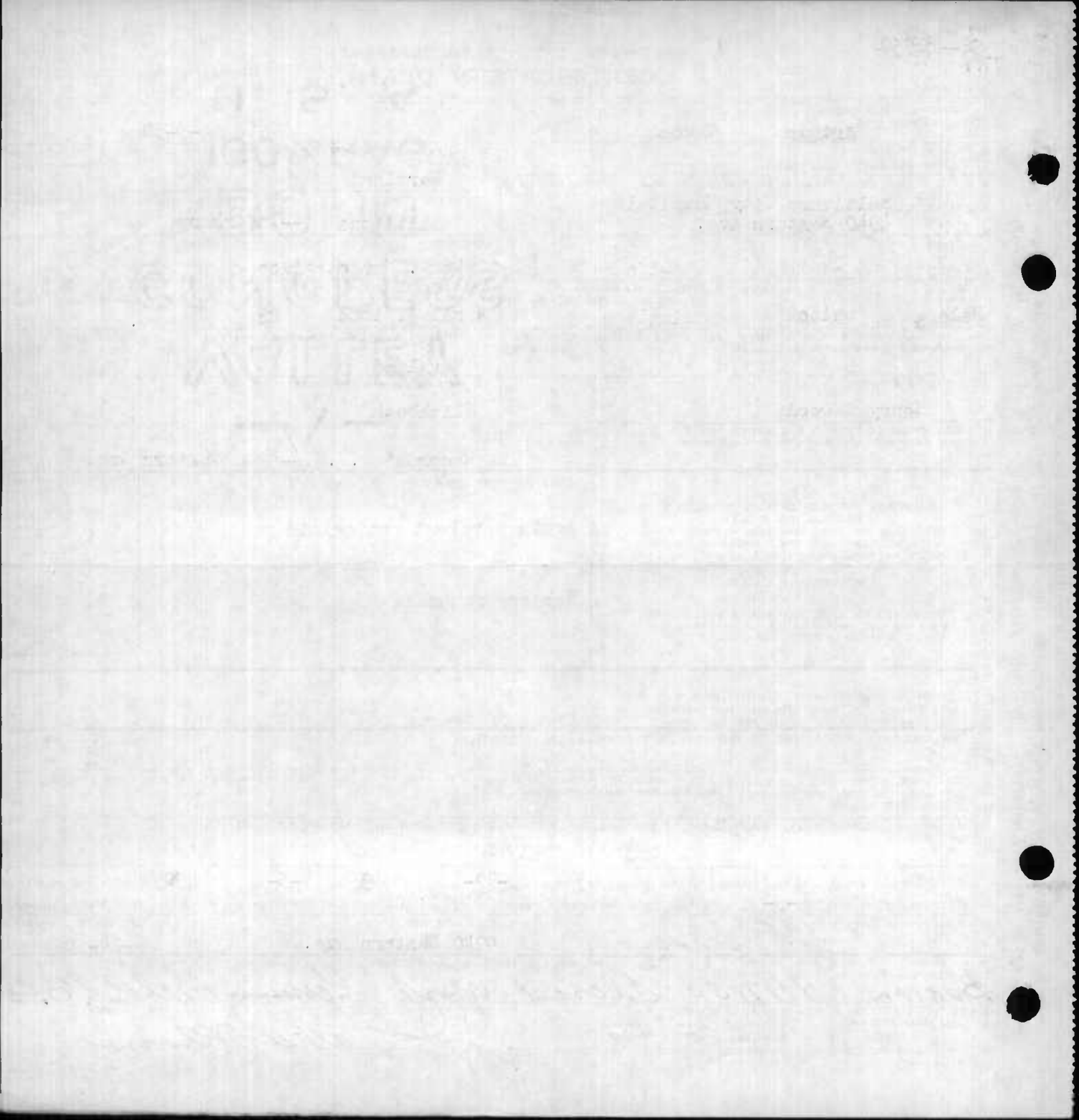
300  
BIRTH NO. 1750

1. NAME OF DECEASED (Type or Print) <b>Arthur Cawood</b>			2. DATE OF DEATH <b>4-5-50</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore --Infirmery 4-01</b>		
c. Length of stay in Baltimore <b>Life</b> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>46 W. Market Place</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>April 5, 1862</b>	9. AGE (In years last birthday) <b>88</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>✓</b>
13. FATHER'S NAME <b>Henry Cawood</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Records* B.C.H.--4940 Eastern Ave.</b>		

18. <b>491 X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute purulent meningitis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Bronchopneumonia</b> DUE TO (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma of tongue</b>			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>5-29-</b> , 19 <b>43</b> , to <b>4-5-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-5-</b> , 19 <b>50</b> , and that death occurred at <b>1:40 P.m.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>[Signature]</b> M. D.		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>4-14-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4/17/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	24D. LOCATION (City, town, or county) (State) <b>German Hill Rd B.C.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>[Signature]</b>		

VS 150

45B





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3520BIRTH NO. 50 3520

1. NAME OF DECEASED (Type or Print) <u>Huber Henry J.</u>			2. DATE OF DEATH <u>4-14-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>24-03</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <u>1236 Wall Street</u>		
c. Length of stay in Baltimore <u>42</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>Baltimore</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2/23 1876</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <u>Christina</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <u>610X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Benign Hypertrophy of prostate</u>			?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pulmonary edema</u>			<u>1 hr</u>
19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/17</u> , 19 <u>50</u> , to <u>4/14</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>50</u> , and that death occurred at <u>7:45 p.m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>Huber</u>	23B. ADDRESS <u>SBC&amp;H</u>	23C. DATE SIGNED <u>4/15/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>8</u>	24B. DATE <u>4/18/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Stoey Cross</u>	24D. LOCATION (City, town, or county) (State) <u>Reschie Highway</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 17 1950</u>	REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>	25. FUNERAL DIRECTOR ADDRESS <u>J. J. Foley Sons 1318 Light</u>	

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 17 1950

308 V9

937

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3521

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ERNEST W. LAMBETH.

2. DATE  
OF  
DEATH

4/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University of Maryland Hosp.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

28-04

D. STREET ADDRESS (If rural, give location)

802 Walnut Ave

c. Length of stay in Baltimore

- 50

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov 16, 1882

9. AGE (In years  
last birthday)

67.

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

claim agent

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Charles Lambeth

14. MOTHER'S MAIDEN NAME

Sally Peatross

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Wife

ADDRESS

Same.

18. 44 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Congestive Heart Failure.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Chronic glomerulonephritis

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/3 1950, to 4/13 1950, that I last saw the  
deceased alive on 4/13 1950, and that death occurred at 9:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Mark E. Holt, Jr.

M. D.

23B. ADDRESS

U of Md Hosp

23C. DATE SIGNED

4/13/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 17/50

24C. NAME OF CEMETERY OR CREMATORY

Gruid Ridge

24D. LOCATION (City, town, or county)

Lakesville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Harry H. Wylie 4101 Edmondson Ave

ADDRESS

STATE OF TEXAS

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3522

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Edward

EISENHAUER

2. DATE  
OF  
DEATH

April 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore  
1511 Ramsay Street

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

12/24/1897

9. AGE (In years last birthday)

52

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Patrolman

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

John W Eisenhauer

14. MOTHER'S MAIDEN NAME

Sophia Morthley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

(If yes, give war or dates of service)

1921

16. SOCIAL SECURITY NO.

18-14-7455

17. INFORMANT

Edgar C. Filliaux

ADDRESS

1511 Ramsay St

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Artery Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Edgar C. Filliaux

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED

April 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/17/50

24C. NAME OF CEMETERY OR CREMATORY

Randoms Pk

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

DD 17 1950

REGISTRAR'S SIGNATURE

Edgar C. Filliaux

25. FUNERAL DIRECTOR

Robert B. M. Walters

ADDRESS

1511 Ramsay St

VS 151

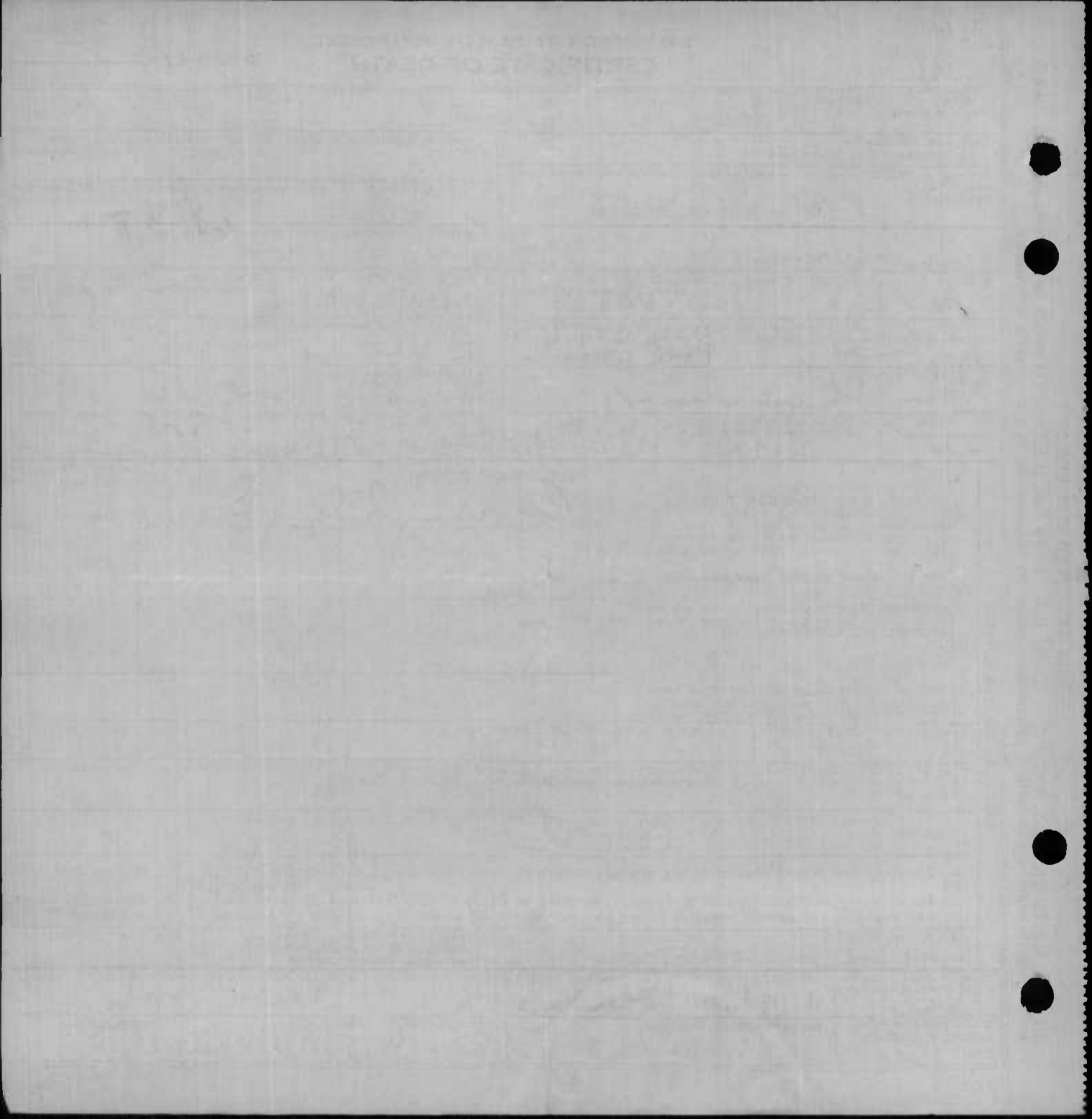
98898

94a

Stucky

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

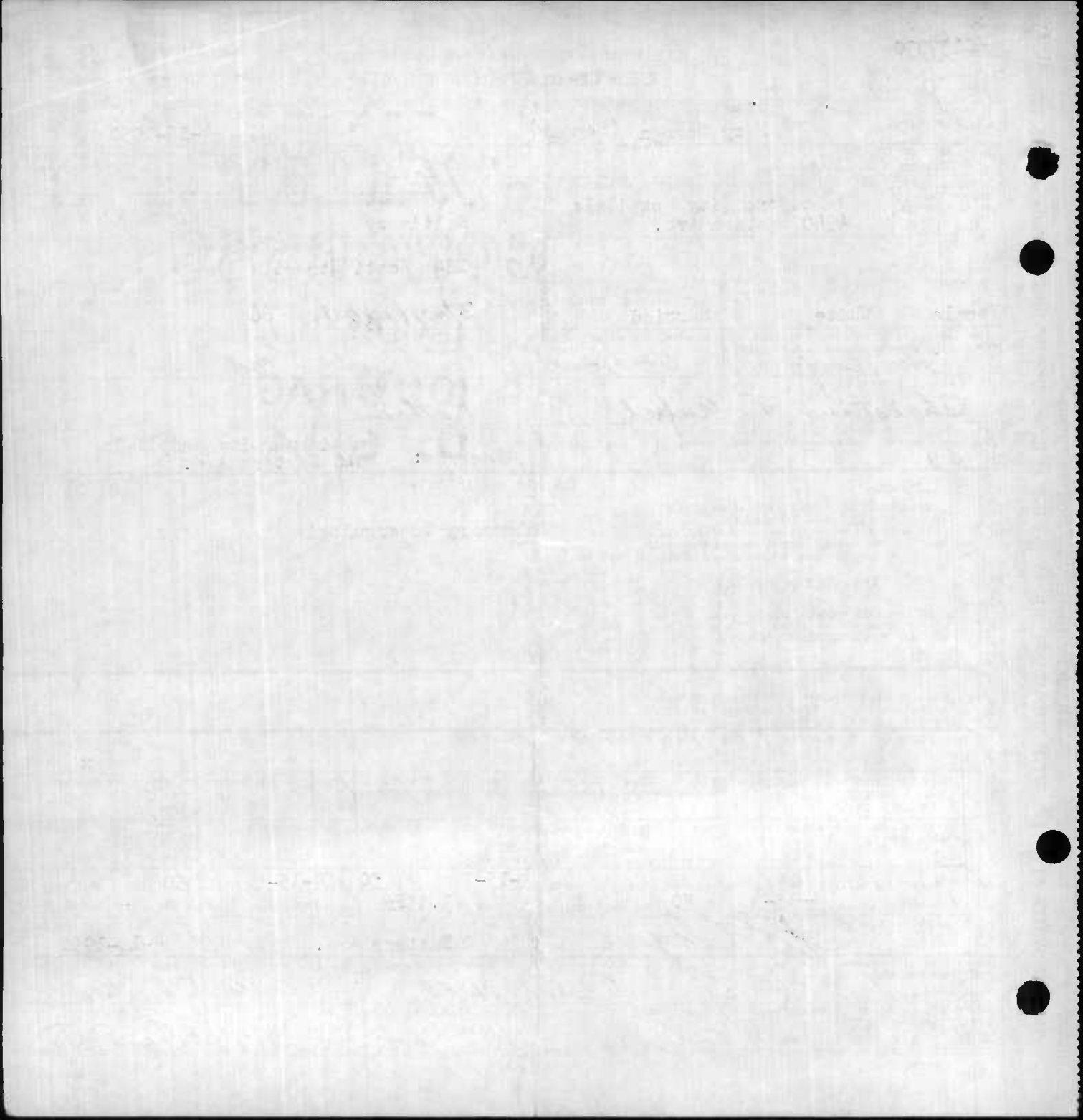




BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3523

1. NAME OF DECEASED (Type or Print) <b>Mary Seamon (Semone)</b>			2. DATE OF DEATH <b>4-15-1950</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY		
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) <b>124 Scott Street</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3/27/1884</b>	9. AGE (in years last birthday) <b>66</b>	10. Under 1 Year Months: Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Christian T. Anpel</b>			14. MOTHER'S MAIDEN NAME <b>Kathrine R</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Baltimore City Hospitals Records: 4940 Eastern Ave.</b>			ADDRESS		
18. <b>002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION <b>2</b>			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-15</b> , 19 <b>50</b> , to <b>4-15</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-15</b> , 19 <b>50</b> and that death occurred at <b>3:15 Pm.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>J. S. Cohen</b>			23b. ADDRESS <b>4940 Eastern Ave.</b>		23c. DATE SIGNED <b>4-16-1950</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4/18/50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		24d. LOCATION (City, town, or county) (State) <b>A. G. Co. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams</b>		25. FUNERAL DIRECTOR <b>Wm Cook Inc</b>	
				ADDRESS <b>1217 St. Paul St.</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3524

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LAURA EMRICH

2. DATE  
OF  
DEATH

4-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1701 No. Ellement St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Templatt Home

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Cylburne apts 1F

c. Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

M. Solomon Cohen Cylburne apts

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Marasmus senilis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

general arteriosclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Feb. 1950 to April 16, 1950, that I last saw the  
deceased alive on April 14, 1950, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Harold H. Bix

M. D.

23B. ADDRESS

2516 Linden Ave

23C. DATE SIGNED

4-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 17 1950

[Signature]

Jack Lewandowski

2100 Eutan Pl

But  
Georgian Court  
Linden r Brooks Lane

---

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Daniel Rehr

2. DATE  
OF  
DEATH

April 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Mary Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-03

C. Length of stay in Baltimore

26

D. STREET ADDRESS (If rural, give location)

1600 Warwick Ave.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 12, 1902

9. AGE (In years last birthday)

47

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Grocery Store

11. BIRTHPLACE (State or foreign country)

Austria

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Philip Rehr

14. MOTHER'S MAIDEN NAME

Jenny Cherry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Philip Rehr - 3345 Franklinton Rd.

18.

420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

1 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute Myocardial Infarction

1 hr.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Acute Coronary Occlusion

1 hr.

Chronic Coronary Insufficiency

4 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 16, 1950, to April 16, 1950, that I last saw the deceased alive on April 16, 1950, and that death occurred at 5:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL CREMATION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

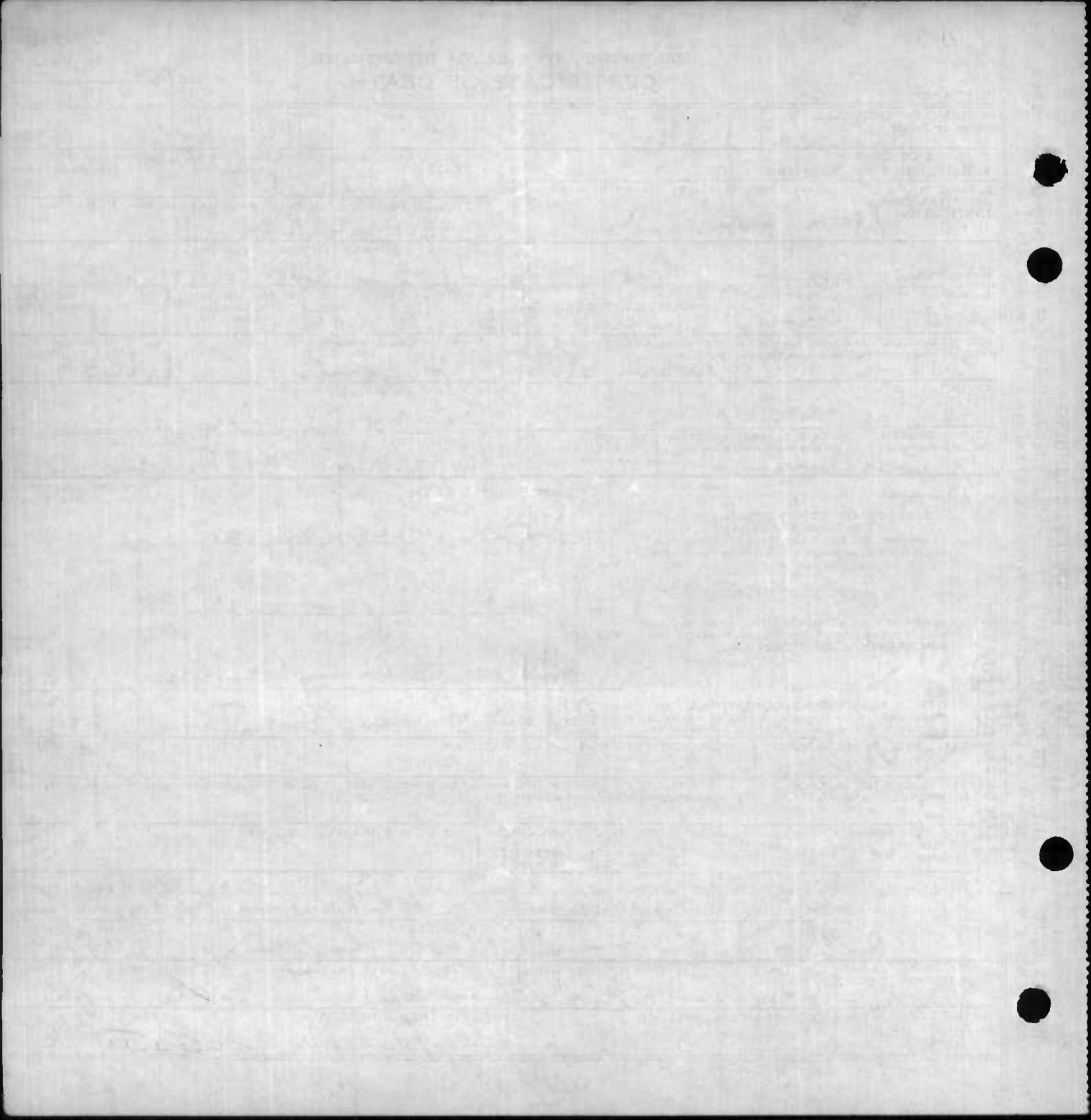
ADDRESS

APR 17 1950

Thompson

Jack Hewes

2100 Canton Pl





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3526

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edith K. Mercl

2. DATE  
OF  
DEATH

Apr. 15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2909 Oak Hill Rd.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

DO

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

2909 Oak Hill Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. Md.

D. STREET ADDRESS (If rural, give location)

2909 Oak Hill Ave.

c. Length of stay in Baltimore

40yrs

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Female

White

Widow

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

13. FATHER'S NAME

Samuel Shaffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Robert A. Coltrane, 607 MT. Holly Street

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

acute coronary occlusion  
coronary sclerosis  
arteriosclerosis generalized  
myocarditis  
Congestive failure & decompensation  
Basal Cell Epithelioma Left Occipital

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORKNOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 22, 1949, to April 15, 1950, that I last saw the deceased alive on April 14, 1950, and that death occurred at 6:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 18, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county) (State)

Balto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 17 1950

[Signature]

Philip H. [Signature]

2024 Orleans St.

VS 150

5413

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Domestic Plant Industry

1912-1913

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

PLANT INDUSTRY

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PLANT INDUSTRY

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3527  
Registered No.

BIRTH NO. 50 3527

1. NAME OF DECEASED  
(Type or Print)

Mary Chaney

2. DATE  
OF  
DEATH

4-14-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

STATE

B. COUNTY

before admission)

Maryland

AnneArundal

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

Baltimore City Hospitals  
4940 Eastern Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Rural) Crownsville

D. STREET ADDRESS (If rural, give location)

Crownsville State Hospital

C. Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

3-23-1900

9. AGE (in years  
last birthday)

50?

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

DANVILLE

VA-

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

HENRY EDWARD

14. MOTHER'S MAIDEN NAME

HANNAH WALTERS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 260 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Diabetes mellitus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Osteomyelitis of symphysis pubis

19A. DATE OF OPERATION

4-12-1950

19B. MAJOR FINDINGS OF OPERATION

Abscess right thigh

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-10-1950 to 4-14-1950, that I last saw the  
deceased alive on 4-14-1950 and that death occurred at 4:15am., from the causes and on the date stated above.

23A. SIGNATURE

R. S. Egan

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-16-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4-19-50

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

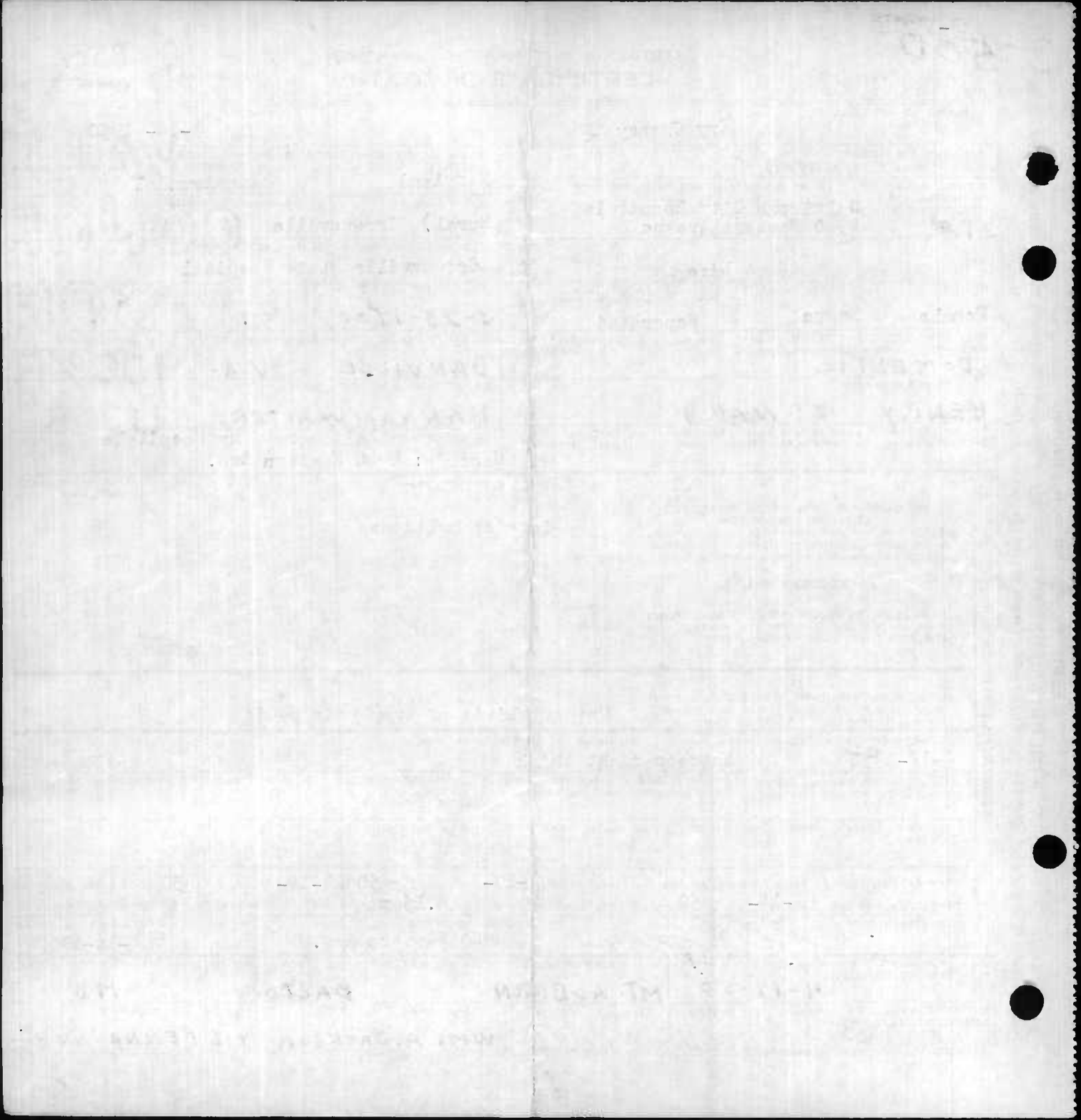
REGISTRAR'S SIGNATURE

Wm. A. Jackson

25. FUNERAL DIRECTOR

ADDRESS

WM. A. JACKSON 916 PENNA AVE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH BASNIGHT

2. DATE  
OF  
DEATH

4-13-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

614 PERKINS AVE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BAITIMORE 1.

D. STREET ADDRESS (If rural, give location)

614 PERKINS AVE.

c. Length of stay in Baltimore

30 YRS.

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

APRIL 10, 1902

9. AGE (in years, last birthday)

48

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

GORDON CARTON

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

ELLIS

BASNIGHT

14. MOTHER'S MAIDEN NAME

JOELLER

MIDGETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

231-01-7136

17. INFORMANT

ADDRESS

ROSCOE BASNIGHT-614 PERKINS AVE

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

6 days

ANTECEDENT CAUSES.

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

Hypertension

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11/50, to 4/13/50, that I last saw the deceased alive on 4/12/50, and that death occurred at 12:00 PM, from the causes and on the date stated above.

23A. SIGNATURE

Wm. Canner

M. D.

23B. ADDRESS

753 Gough St

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-17-50

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN

24D. LOCATION (City, town, or county)

BAITIMORE 30.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 17 1950

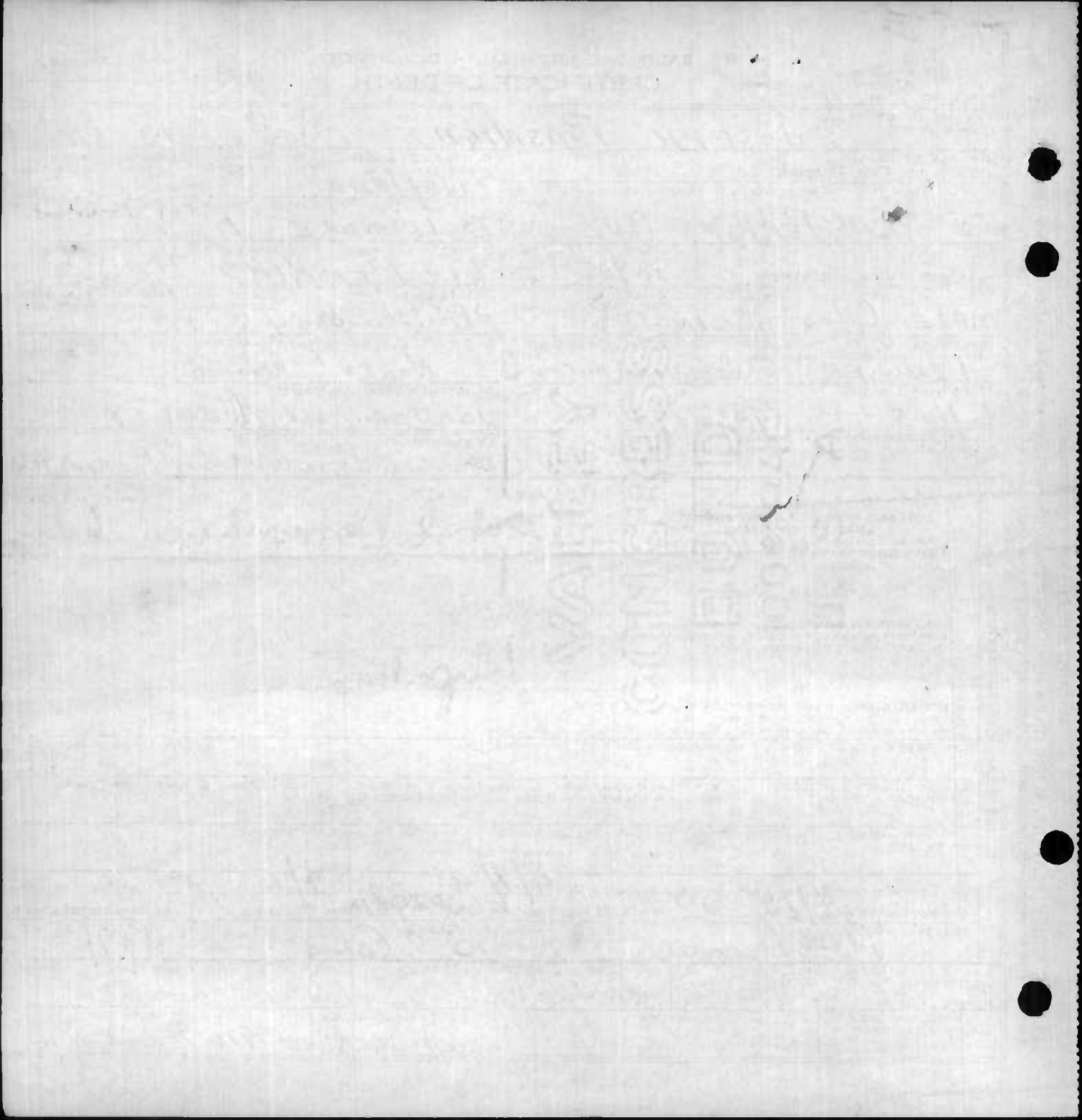
REGISTRAR'S SIGNATURE

Wm. Canner

25. FUNERAL DIRECTOR

ADDRESS

Wm. A. JACKSON-916 PENNA. AVE.





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3529

BIRTH NO. 50 3529

1. NAME OF DECEASED  
(Type or Print)

GEORGE W. MEYERS

2. DATE  
OF  
DEATH

APR. 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

6028 OLD HARFORD RD.

C. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD.

B. COUNTY

C. CITY OR TOWN BALTO.

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5631 GOVANE AVE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

SEPT. 7, 1874

9. AGE (In years last birthday)

75

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PRESSMAN

10B. KIND OF BUSINESS OR INDUSTRY

PRINTING

13. FATHER'S NAME

MEYERS

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS. G. W. MEYERS

ADDRESS

SAME

18. 4221

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

(A)

Arteriosclerosis Coronary Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

(C)

INTERVAL BETWEEN ONSET AND DEATH

app. 18 min.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Coronary Arteriosclerosis

6 min.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1300 hrs., 1946, to 1500 hrs., 1950, that I last saw the deceased alive on 15 Apr., 1950, and that death occurred at 10 A. M., from the causes and on the date stated above.

23A. SIGNATURE

H. W. Jenkins

23B. ADDRESS

1513 N. M. St. Balto.

23C. DATE SIGNED

17 Apr. 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-19-1950

24C. NAME OF CEMETERY OR CREMATORY

BALTO.

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

DATE RECEIVED BY LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

H. W. Jenkins

25. FUNERAL DIRECTOR

H. W. JENKINS &amp; SONS Co. YORK RD.

ADDRESS

4905

15100  
Z  
Z  
10500  
Z  
15100

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3530

BIRTH NO. 50 3530

1. NAME OF DECEASED (Type or Print) <b>Mr. George Joseph Sweeder (Swiderski)</b>			2. DATE OF DEATH <b>April 15, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>55yr.</b>			D. STREET ADDRESS (If rural, give location) <b>1207 S. Decker Ave., Balto.-24 Md.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>MARCH 31 1891</b>		9. AGE (In years last birthday) <b>59</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Amer. Smelting U Refining Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Buffalo, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>MICHAEL SWIDERSKI</b>			14. MOTHER'S MAIDEN NAME <b>MARIANNA JANKA.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-1729</b>	17. INFORMANT ADDRESS <b>HELEN K. SWIDERSKI 1207 S DECKER AVE</b>		

18. <b>180 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma</b> DUE TO <b>probably carcinoma of left kidney</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerosis</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>Apr. 14, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma, Rt. Main Stem Bronchus</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/3/50</b> , 19__, to <b>4/15/</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/15/</b> , 19 <b>50</b> , and that death occurred at <b>10:30AM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Madame Swinski</b>		23B. ADDRESS <b>1400 N. Caroline Street</b>		23C. DATE SIGNED <b>4/15/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>APRIL 18-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>GERMAN HILL RD MD.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Dippel Bros 1800 E LOMBARD ST</b>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

CRIMINAL DIVISION

WASHINGTON, D. C. 20535

MEMORANDUM FOR THE ATTORNEY GENERAL

DATE: 10/10/68

TO: THE ATTORNEY GENERAL

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. [REDACTED]

25. [REDACTED]

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

38. [REDACTED]

39. [REDACTED]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3531

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHESTON M STOUT

2. DATE  
OF  
DEATH

APRIL 16-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND. Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

BON SECOURS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

5300

c. Length of stay in Baltimore

LIFE

D. STREET ADDRESS (If rural, give location)

6612 LOCH HILL RD

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT 28 1883

9. AGE (In years  
last birthday)

66

H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SELF

10B. KIND OF BUSINESS OR  
INDUSTRY

REAL ESTATE.

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE STOUT

14. MOTHER'S MAIDEN NAME

EMMA HUGHES

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MARY M STOUT 6612 LOCH HILL RD.

18.

165X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

cerebral Hemorrhage, left side

24 Hrs.

ANTECEDENT CAUSES

(B)

DUE TO

Atherosclerosis, Rt. lung.

24 Hrs.

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

DUE TO

Pneumonia, Rt. lung

24 Hrs.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Metastatic Carcinoma, Rt. lung

About 1 year

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 4-10, 1950 to 4-16, 1950 that I last saw the  
deceased alive on 4-16, 1950 and that death occurred at 5:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph R. Dake

M. D.

23B. ADDRESS

Bon Secours Hosp.

23C. DATE SIGNED

4-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

APRIL 19-1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL CEM.

24D. LOCATION (City, town, or county)

OLD FREDERICK RD MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 17 1950

Opfel Bros. 7110 BELAIR RD.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

OFFICE OF THE COMMISSIONER OF HEALTH

ALBANY, NEW YORK

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3532

BIRTH NO. 432 3532

1. NAME OF DECEASED  
(Type or Print)

Joseph George Goldsmith

2. DATE  
OF  
DEATH

April 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)

INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

28-01

D. STREET ADDRESS (If rural, give location)

4210 Oakford Avenue

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 7, 1886

9. AGE (In years  
last birthday)

63

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Buyer

10B. KIND OF BUSINESS OR  
INDUSTRY

Dept. Store

11. BIRTHPLACE (State or foreign country)

Cleveland, Ohio

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Morris Goldsmith

14. MOTHER'S MAIDEN NAME

Bertha Wertheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
216-03-3188

17. INFORMANT

ADDRESS

U.M. Hospital Records, Balt.

18. 442X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Nephrosclerosis (Uremia)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive Cardiovascular  
Disease

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from April 10, 1950, to April 14, 1950, that I last saw the  
deceased alive on April 14, 1950, and that death occurred at 9:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William A. Ravson

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

April 14, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

4/17/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

New York, N. Y.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 17 1950

William A. Ravson

Wm. J. Dickener &amp; Sons Balt. Md.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. GOVERNMENT PRINTING OFFICE

1975 O-374-101

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

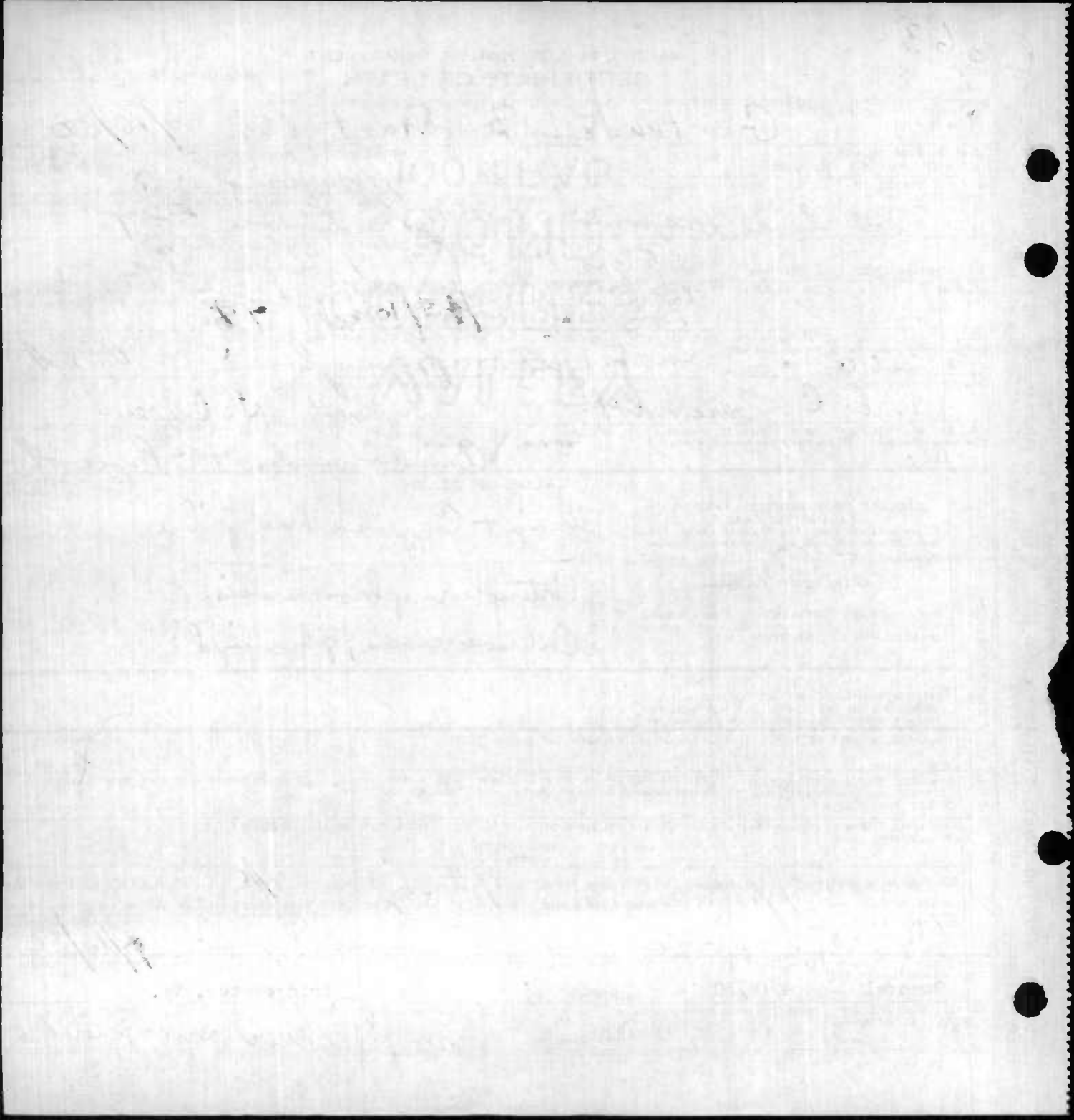
663

50 3533

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3533  
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Gertrude E. Earehart		4/16/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institutions residence before admission) A. STATE B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION H. Agnes Hospital		C. CITY OR TOWN Baltimore	
c. Length of stay in Baltimore 23 yrs.		D. STREET ADDRESS (If rural, give location) 429 Gwynn Ave.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 10/22/71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurses		11. BIRTH PLACE (State or foreign country) Pennsylvania	
10B. KIND OF BUSINESS OR INDUSTRY hats (retail)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James C. Earehart		14. MOTHER'S MAIDEN NAME Elizabeth H. Cagney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Annie Schneider		ADDRESS 409 Bryce St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 442X I Anemia + Congestive heart failure		CAUSE OF DEATH DUE TO (A) Arteriolaryphrosclerosis	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO (B) Arteriosclerosis, generalized	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/4, 1950, to 4/16, 1950, that I last saw the deceased alive on 4/16, 1950, and that death occurred at 3:40 p.m., from the causes and on the date stated above.			
23A. SIGNATURE Robert J. Surickas		23B. ADDRESS St. Agnes Hospital	
23C. DATE SIGNED 4/16/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/18/50	
24C. NAME OF CEMETERY OR CREMATORY B		24D. LOCATION (City, town, or county) (State) Bridgewater, Va.	
DATE RECEIVED BY LOCAL REGISTRAR APR 17 1950		REGISTRAR'S SIGNATURE Win. J. Trickett	
25. FUNERAL DIRECTOR Win. J. Trickett		ADDRESS Law - Balt Md.	

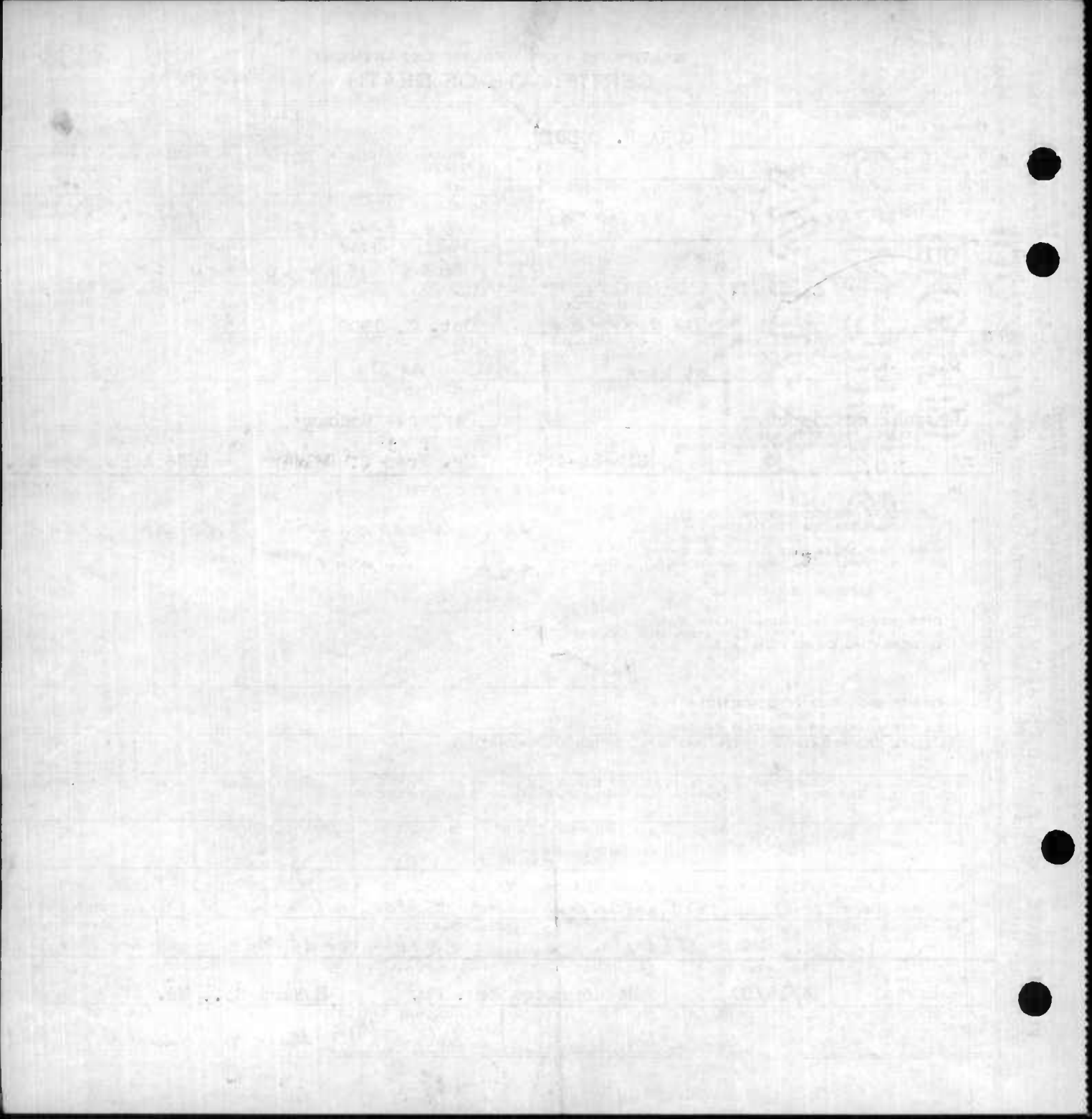


BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3534G-435  
50 3534  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CORA P. GOLDIN</b>			2. DATE OF DEATH <b>4-15-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>UN</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>15-06</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>		
c. Length of stay in Baltimore Yrs. <b>38</b> Mos. <b>1635</b> Days <b>ASHBURTON ST.</b>			D. STREET ADDRESS (If rural, give location)		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Oct. 3, 1900</b>	9. AGE (In years last birthday) <b>49</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Lemmuel Brandenburg</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Conoway</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-24-4181</b>	17. INFORMANT ADDRESS <b>Mr. Fred C. Goldin 1635 Ashburton St.</b>		

18. <b>170 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>CARCINOMA OF BREAST 2 YEARS</b> DUE TO <b>AND OVARY</b> (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>4-13</b> , 19 <b>50</b> , to <b>4-15</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-15</b> , 19 <b>50</b> , and that death occurred at <b>4:20 AM</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>John W. Stover</b> M.O.	23B. ADDRESS <b>UNIV HOSP</b>	23C. DATE SIGNED <b>4-15-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/18/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>
24D. LOCATION (City, town, or county) (State) <b>Howard Co., Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Tichenor &amp; Sons Bldg. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>		
REGISTRAR'S SIGNATURE <b>Wm. J. Tichenor</b>		







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3535  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSIAH HALL AIKEN, Sr.

2. DATE  
OF  
DEATH

April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

422 E. Lake Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

422 E. Lake Ave -

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore, Md. 27-12

c. Length of stay in Baltimore

Life -

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

422 E. Lake Ave

5. SEX

m

6. COLOR OR RACE

w.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 7, 1886

9. AGE (In years last birthday)

63

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tile Contractor

10B. KIND OF BUSINESS OR INDUSTRY

Own Tile Business

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Aiken

14. MOTHER'S MAIDEN NAME

Alice Maude Lemmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

J. Hall Aiken Jr

ADDRESS

bookham pky

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

acute coronary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

hypertensive cardiovascular disease

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1945, to April 15, 1950, that I last saw the deceased alive on April 11, 1950, and that death occurred at 5A. m., from the causes and on the date stated above.

23A. SIGNATURE

Jack J. Singer

23B. ADDRESS

506 E. North Ave

23C. DATE SIGNED

4-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

4/18/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Wm. J. Stickner Balto. Md.

ADDRESS

CERTIFICATE OF DEATH

4

1911

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3536

Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Iver Sydnor

2. DATE  
OF  
DEATH

4-14-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1037 N Strickon St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

1037 N. Strickon St.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Jan. 31, 1893

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

King & Queens Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Squire Ellis

14. MOTHER'S MAIDEN NAME

Emma Wheelon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS 1037 N Strickon St.

Harold Sydnor

18.

331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

Sunday

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

very much

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-11-1950, to 4-14-1950, that I last saw the deceased alive on 4-13-1950 and that death occurred at 1:23 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Frank A. Saunders, M. D.

23B. ADDRESS

1029 N. Strickon St.

23C. DATE SIGNED

4-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

April 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

W. T. Auburn Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Mrs. Kate Williams

ADDRESS

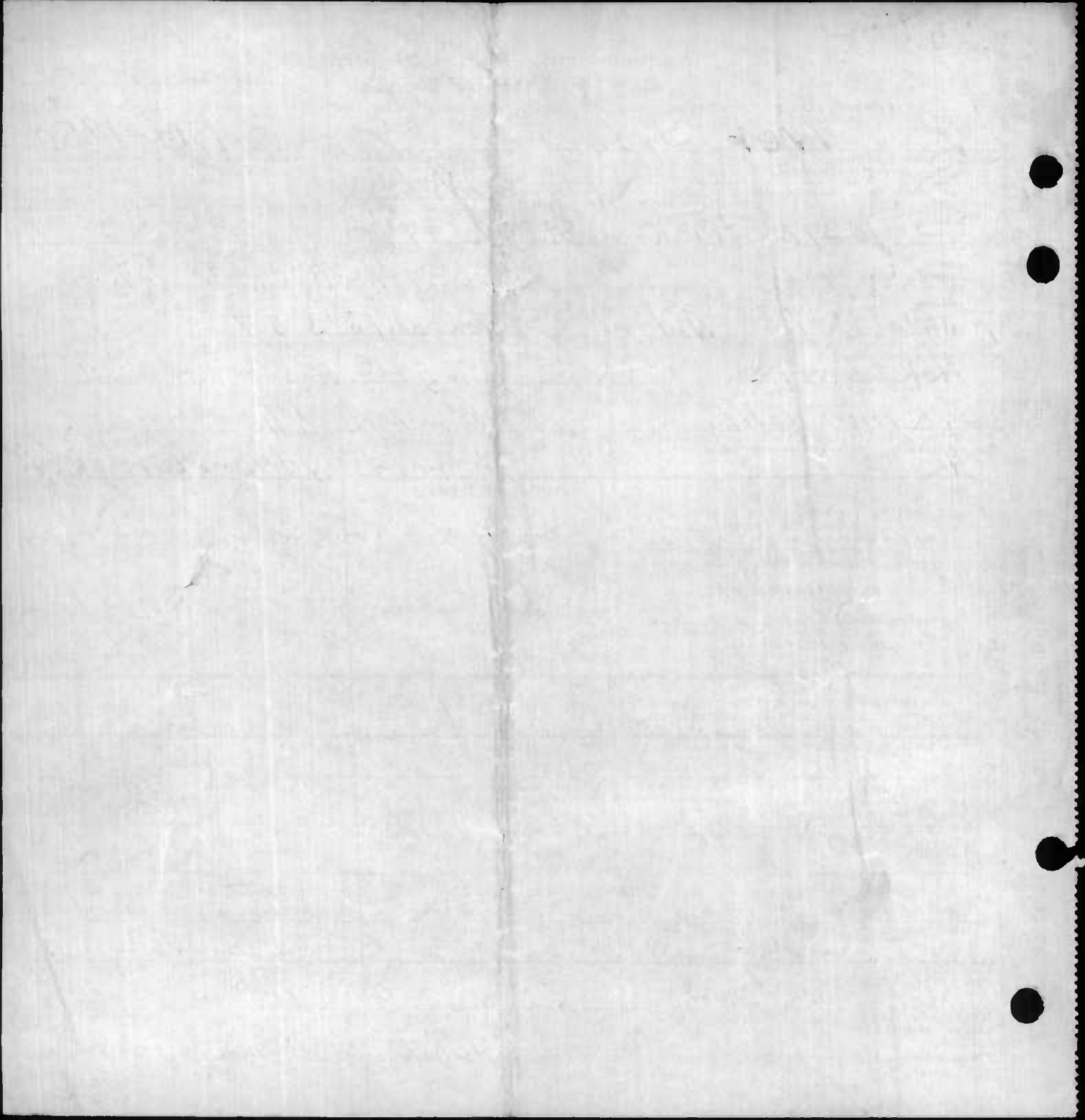
322 N. Schenck St.

APR 17 1950

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.



B-620  
50 3537BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3537

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edith Brooks

2. DATE  
OF  
DEATH

April 14 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

1305 Edmondson Ave

c. Length of stay in Baltimore

5. SEX

Female Col.

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Balto. 19-01

D. STREET ADDRESS (If rural, give location)

1305 Edmondson Ave.

8. DATE OF BIRTH

Sept. 15, 1879 70

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

14. MOTHER'S MAIDEN NAME

Amelia Lann

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Hattie Campbell

ADDRESS 537  
Dolphin St

18. 151X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Malnutrition

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

4 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Intestinal Obstruction

DUE TO

4 mos.

(C) Gastric Carcinoma

2 yrs (?)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1949 to 4/14, 1950, that I last saw the  
deceased alive on 4/10, 1950, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Preston Grant

M. D.

23B. ADDRESS

601 N. Carrollton

23C. DATE SIGNED

4/15/50

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

April 19, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem. Balto.

24D. LOCATION (City, town, or county)

Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington, N.C.

25. FUNERAL DIRECTOR

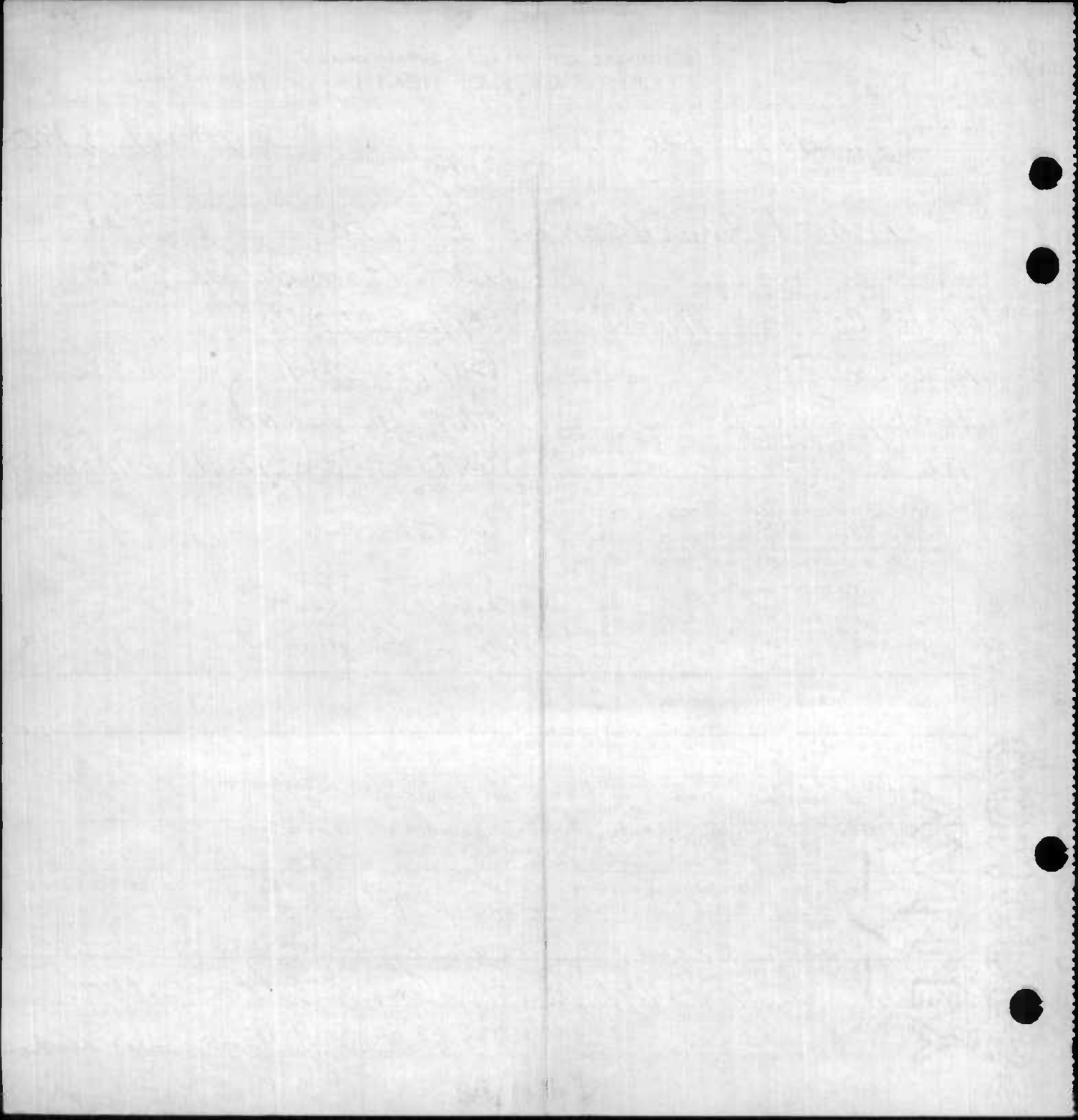
Mrs. Kate R. Williams

ADDRESS 322 N

Schneider St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3538

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>BESSIE HILL</b>			2. DATE OF DEATH <b>4-13-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY Hosp.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTO. 16-02</b>		
C. Length of stay in Baltimore <b>LIFE</b> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>1506 MOSHER STREET</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>5-16-04</b>		9. AGE (In years last birthday) <b>46</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic worker</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>OSCAR HILL</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA MORSE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Ester Bivens 1506 Mosher St.</b>		

18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive cardiac-vascular disease</b> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-12</b> , 19 <b>50</b> , to <b>4-13</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-13</b> , 19 <b>50</b> , and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Gene R. Hunt</b>		23B. ADDRESS <b>Cherry Hosp.</b>		23C. DATE SIGNED <b>4-13-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 18, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>977 Calvary Ave Cedar Hill Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		25. FUNERAL DIRECTOR <b>Mrs. Kate R. Williams</b>		ADDRESS <b>322 N. Schroeder St.</b>	

OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]

[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 3539**

BIRTH NO. **236**

1. NAME OF DECEASED  
(Type or Print)

**ERNEST**

**LASSITER**

2. DATE  
OF  
DEATH

**April 10, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

**Maryland**

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

**University Hospital**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

D. STREET ADDRESS (If rural, give location)

**919 Argyle Avenue**

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**Colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Single**

8. DATE OF BIRTH

**Feb. 25/13**

9. AGE (In years last birthday)

**37**

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**g.i. student**

10B. KIND OF BUSINESS OR INDUSTRY

**Tailoring**

11. BIRTHPLACE (State or foreign country)

**Raleigh N. C.**

12. CITIZEN OF WHAT COUNTRY?

**U. S. A.**

13. FATHER'S NAME

**John Lassiter Sr.**

14. MOTHER'S MAIDEN NAME

**Holly Morgan**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**Yes**

**W. W. #2**

16. SOCIAL SECURITY NO.

17. INFORMANT

**John Lassiter**

ADDRESS

18. **581.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Hepatitis and gastro-enteritis-toxic**  
**etiology not discovered**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Chronic alcoholism**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE

**H. J. Mc Clafferty**

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

**4-11-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

**4/17/50**

24C. NAME OF CEMETERY OR CREMATORY

**Balto. Nat'l Cemetery**

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**William H. Williams, M.D.**

25. FUNERAL DIRECTOR

**W. Halstead**

ADDRESS

**918 - ✓**

**APR 17 1950**

VS 151

**41265 - Remind Still are 124a**

STATE OF TEXAS

CERTIFICATE OF DEATH

IN THE COUNTY OF DALLAS

STATE OF TEXAS

CERTIFICATE OF DEATH

IN THE COUNTY OF DALLAS

STATE OF TEXAS

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IN THE COUNTY OF DALLAS

STATE OF TEXAS

CERTIFICATE OF DEATH

IN THE COUNTY OF DALLAS

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3540  
Registered No.

BIRTH NO. 50 3540

1. NAME OF DECEASED (Type or Print) <b>KAROL KORPISZ</b>		2. DATE OF DEATH <b>April 15, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>2029 E. Lombard Street</b>		E. Yrs. Mos. Days	
C. Length of stay in Baltimore		8. DATE OF BIRTH <b>11-3-1888</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	9. AGE (In years last birthday) <b>61</b>	10. Under 1 Year Months Days
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>		12. CITIZEN OF WHAT COUNTRY?	
10B. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. R.R.</b>		14. MOTHER'S MAIDEN NAME <b>K</b>	
13. FATHER'S NAME <b>Korpisz</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>705-07-6161</b>		17. INFORMANT <b>Helen Korpish</b> ADDRESS <b>2029 E. Lombard St</b>	

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		
(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>M. J. Mc Clafferty</b>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/>		23C. DATE SIGNED <b>April 15, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/18/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Co.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 15 1950</b>		REGISTRAR'S SIGNATURE <b>William</b>		25. FUNERAL DIRECTOR <b>Wm. S. Fialkowski</b> ADDRESS <b>2007 Eastern</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

SIGNATURE OF WITNESSES

SIGNATURE OF DECEASED

SIGNATURE OF NEXT OF KIN

SIGNATURE OF CLERGYMAN

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF DISTRICT ATTORNEY

SIGNATURE OF COUNTY CLERK

SIGNATURE OF TOWNSHIP CLERK

SIGNATURE OF VILLAGE CLERK

SIGNATURE OF CITY CLERK

SIGNATURE OF STATE CLERK

SIGNATURE OF NATIONAL CLERK

SIGNATURE OF INTERNATIONAL CLERK

SIGNATURE OF UNITED NATIONS CLERK

SIGNATURE OF WORLD CLERK

SIGNATURE OF GALAXY CLERK

SIGNATURE OF UNIVERSE CLERK



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3541  
Registered No. 50 3541

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)M.  
Mrs. Frances Jankiewicz2. DATE  
OF  
DEATH

April 14, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1713 Eastern Avenue

5. SEX

Fe.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar 21-1906

9. AGE (In years  
last birthday)

44

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Hwie.

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George Key

14. MOTHER'S MAIDEN NAME

Pauline Korycki

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, oo or oookooow) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

331 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral hemorrhage  
essential hypertension

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Coronary occlusion, old

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/12/1950, to 4/14/1950 that I last saw the deceased alive on 4/14/1950, and that death occurred at 4:00PM., from the causes and on the date stated above.

23A. SIGNATURE

Thaddeus Swinski

M. D.

23B. ADDRESS

1100 N. Caroline Street

23C. DATE SIGNED

4/14/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

april 18-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltor City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

2007 Eastern Ave  
Wm. S. Zialkowski 94a

STATE OF TEXAS  
COUNTY OF DALLAS

IN SENATE, FEBRUARY 1, 1901.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE.

FOR THE YEAR 1900.

BY

JOHN W. BROWN,

COMMISSIONER.

RECEIVED

AT THE

CLERK'S OFFICE

OF THE

SENATE,

FEBRUARY 1, 1901.

BY

JOHN W. BROWN,

COMMISSIONER.

RECEIVED

AT THE

CLERK'S OFFICE

OF THE

SENATE,

FEBRUARY 1, 1901.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 3542**

 BIRTH NO. **50 3542**

 1. NAME OF DECEASED  
(Type or Print)

**Joseph Pastuszek**

 2. DATE  
OF  
DEATH

**4/13/50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

**Balto City**

B. FULL NAME OF HOSPITAL OR INSTITUTION

**232 S. Collington ave**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Md.**

B. COUNTY

C. CITY OR TOWN

**Balto.**

(If outside corporate limits, write RURAL and give township)

**1-05**

D. STREET ADDRESS (If rural, give location)

**232 S. Collington ave**

c. Length of stay in Baltimore

 Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**1885**

9. AGE (In years, last birthday)

**65**

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Painter**

10B. KIND OF BUSINESS OR INDUSTRY

**Self employed**

11. BIRTHPLACE (State or foreign country)

**Poland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Thomas Pastuszek**

14. MOTHER'S MAIDEN NAME

**Rozalia Szpona**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

 17. INFORMANT ADDRESS  
**Pauline Pastuszek 232 S. Collington ave**

 18. **151X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

**Carcinoma of Stomach (2nd operable)**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

 WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

 22. I hereby certify that I attended the deceased from **Nov. 1, 1949** to **April 13, 1950** that I last saw the deceased alive on **April 13, 1950** and that death occurred at **8:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

**Andrew Stankowski**

23B. ADDRESS

**2529 Eastern ave.**

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**4/17/50**

24C. NAME OF CEMETERY OR CREMATORY

**Holy Rosary**

24D. LOCATION (City, town, or county)

**Balto. Co.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**APR 17 1950**

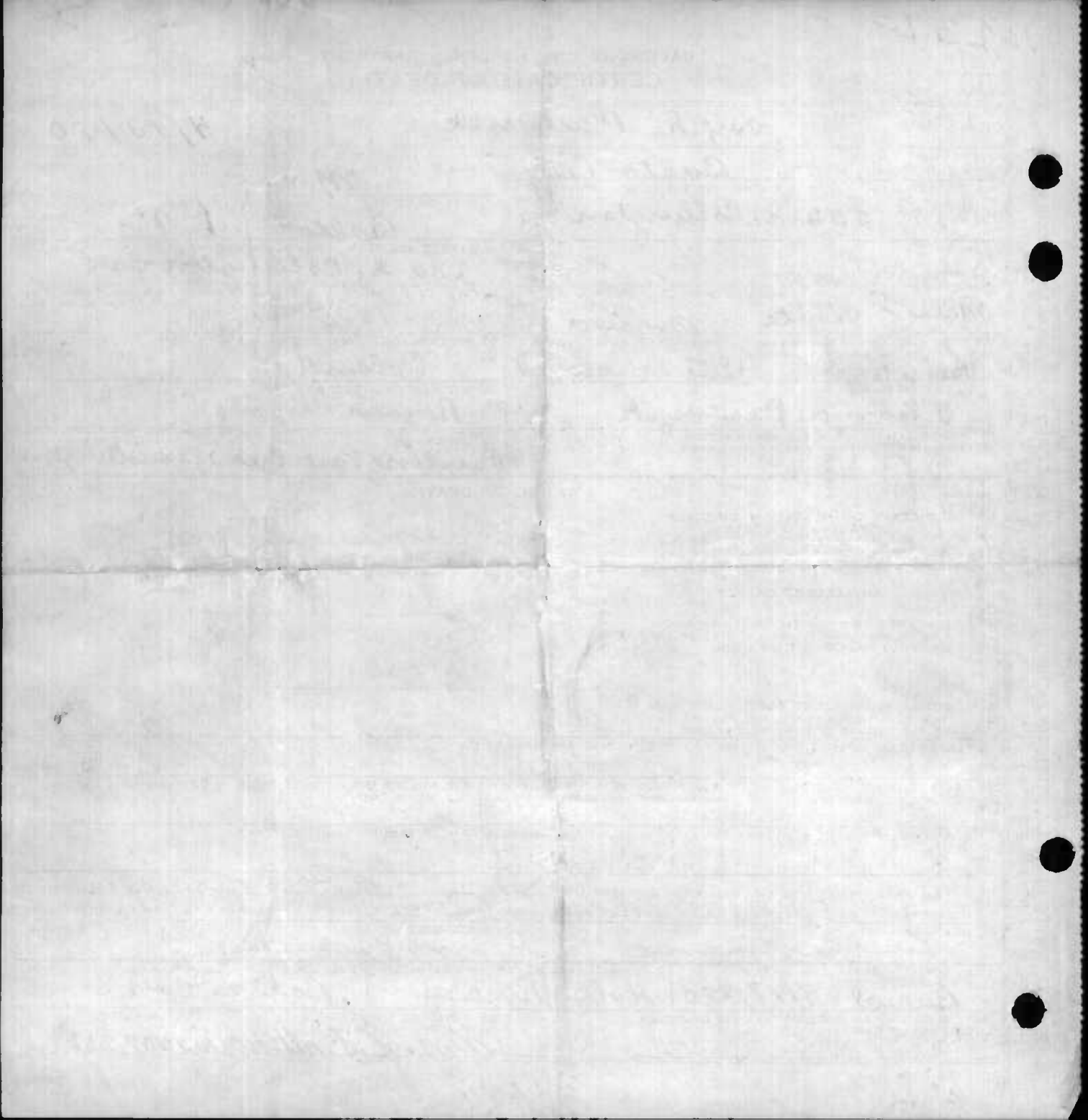
REGISTRAR'S SIGNATURE

**William J. Williams**

25. FUNERAL DIRECTOR,

**Wm. S. Fialkowski 2007 Eastern**

ADDRESS



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3543  
Registered No. \_\_\_\_\_

BIRTH NO. 3543

1. NAME OF DECEASED (Type or Print) <b>James O. Baker</b>		2. DATE OF DEATH <b>April 15, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>924 N. Calvert St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>April 28<sup>th</sup> 1905</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas L. Baker</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Lewis H. Wadsworth, Jr.</b>		ADDRESS	

18. <b>E 982 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Subdural hemorrhage, traumatic</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>	(A) _____ (B) _____ (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Lunchroom</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Victory Lunch, 544 N. Calvert St.</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 13, 1950 11P.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Struck with fist and knocked from stool</b>

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE <b>[Signature]</b>	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. _____	23C. DATE SIGNED <b>April 17, 1950</b>
--------------------------------------	---	---

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 17 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Wadsworth N. C.</b>	24D. LOCATION (City, town, or county) (State) <b>Wadsworth N. C.</b>
--	-----------------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR <b>Lee S. Hooker</b>	ADDRESS <b>1703 N. Patterson Park Ave</b>
--	---	--	--

VS 151  
N-254.0  
46057  
168

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Nature of disease		8. Duration of disease		9. Name of physician		10. Name of funeral director	
11. Name of informant		12. Signature of informant		13. Signature of physician		14. Signature of funeral director		15. Signature of registrar	
16. Name of registrar		17. Signature of registrar		18. Signature of registrar		19. Signature of registrar		20. Signature of registrar	
21. Name of registrar		22. Signature of registrar		23. Signature of registrar		24. Signature of registrar		25. Signature of registrar	
26. Name of registrar		27. Signature of registrar		28. Signature of registrar		29. Signature of registrar		30. Signature of registrar	
31. Name of registrar		32. Signature of registrar		33. Signature of registrar		34. Signature of registrar		35. Signature of registrar	
36. Name of registrar		37. Signature of registrar		38. Signature of registrar		39. Signature of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar		43. Signature of registrar		44. Signature of registrar		45. Signature of registrar	
46. Name of registrar		47. Signature of registrar		48. Signature of registrar		49. Signature of registrar		50. Signature of registrar	
51. Name of registrar		52. Signature of registrar		53. Signature of registrar		54. Signature of registrar		55. Signature of registrar	
56. Name of registrar		57. Signature of registrar		58. Signature of registrar		59. Signature of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar		63. Signature of registrar		64. Signature of registrar		65. Signature of registrar	
66. Name of registrar		67. Signature of registrar		68. Signature of registrar		69. Signature of registrar		70. Signature of registrar	
71. Name of registrar		72. Signature of registrar		73. Signature of registrar		74. Signature of registrar		75. Signature of registrar	
76. Name of registrar		77. Signature of registrar		78. Signature of registrar		79. Signature of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar		83. Signature of registrar		84. Signature of registrar		85. Signature of registrar	
86. Name of registrar		87. Signature of registrar		88. Signature of registrar		89. Signature of registrar		90. Signature of registrar	
91. Name of registrar		92. Signature of registrar		93. Signature of registrar		94. Signature of registrar		95. Signature of registrar	
96. Name of registrar		97. Signature of registrar		98. Signature of registrar		99. Signature of registrar		100. Signature of registrar	



CERTIFICATE CORRECTED 4-24-50

P-400  
50 3544BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3544  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Joshua Poole

2. DATE  
OF  
DEATH

APR-13/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

40 West Balto. Gen Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

5200

D. STREET ADDRESS (If rural, give location)

9 - Overbrook Road

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10 Under 1 Year 11 Under 24 Hours  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country),

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Minnie G. Poole - Same

18. 4/20.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 10, 1947, to 4/13, 1950, that I last saw the deceased alive on 4/10, 1950, and that death occurred at 5:00 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 17 1950

STATE OF TEXAS  
COUNTY OF \_\_\_\_\_  
CERTIFICATE OF DEATH

NAME OF DECEASED \_\_\_\_\_  
AGE \_\_\_\_\_ SEX \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
PLACE OF BIRTH \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_  
PLACE OF DEATH \_\_\_\_\_  
CAUSE OF DEATH \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

DECEASED WAS \_\_\_\_\_  
BY \_\_\_\_\_  
AT \_\_\_\_\_

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3545

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES

J.

(MACH)

MACH

(djm)

2. DATE  
OF  
DEATH

April 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

312 W. Camden Street

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

Dec. 22, 1873

9. AGE (In years  
last birthday)

76

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Machanic (retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

Carnival,

11. BIRTHPLACE (State or foreign country)

Czechoslovakia.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Mach,

14. MOTHER'S MAIDEN NAME

Katherine (last name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

John C. Mach, 3903 Calloway Ave.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

Apr. 17, 1950

Holy Redeemer Cem.

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNDAL DIRECTOR

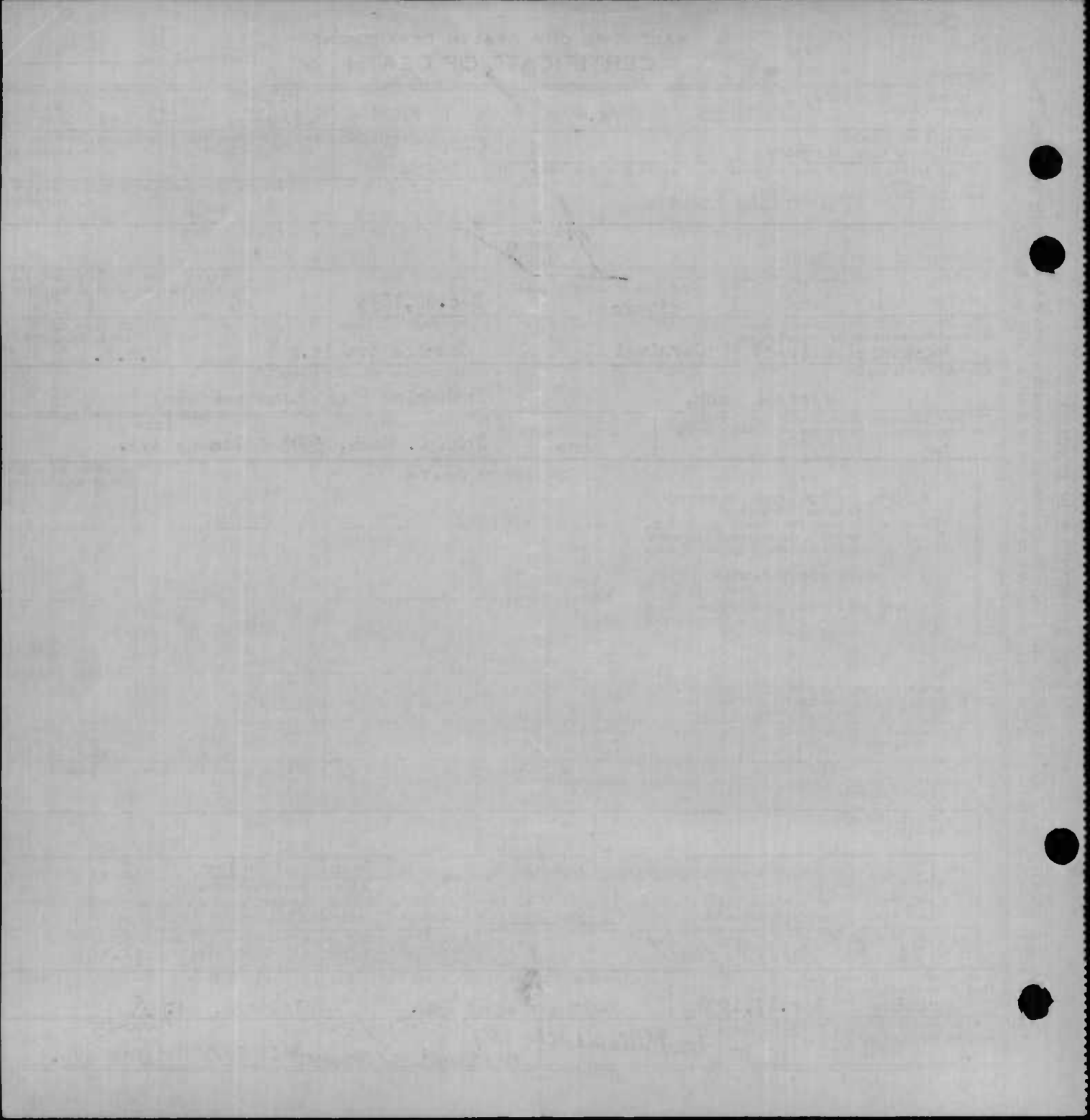
ADDRESS

4/17/50

William M. Williams, M.D.

B. Verman, M.D.

4611 Park Heights Ave.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3546

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. James W. Knight

2. DATE  
OF  
DEATH

4/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

West Virginia

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Church Home &amp; Hospital, Williamsburg, W. Virginia

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

Aug. 6, 1862

9. AGE (In years last birthday)

87

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Owner

10B. KIND OF BUSINESS OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

George W. Knight

14. MOTHER'S MAIDEN NAME

Susan Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. William Elgin Townsend, Md.

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/12, 1950, to 4/16, 1950, that I last saw the deceased alive on 4/16, 1950, and that death occurred at 4:00 P.M. from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Euser

M. D.

23B. ADDRESS

Church Home &amp; Hosp.

23C. DATE SIGNED

4/16/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

4/17/50

24C. NAME OF CEMETERY OR CREMATORY

Creswood Cem.

24D. LOCATION (City, town, or county)

Lewisburg, W. Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 17 1950

REGISTRAR'S SIGNATURE

William Elgin Townsend

25. FUNERAL DIRECTOR

Wm. J. Pickener

ADDRESS

Two Balls





S-160

50 3547

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

50 3547  
 Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Johanna Sebour		4-15-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
Baltimore		A. STATE Md B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
707 S. Ellwood Avenue		Baltimore, Md. 1-01			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
Life		707 S. Elwood Avenue			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
F.	W	Widowed	6-11-56	93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		No		Mrs James Peacock-	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Chronic myocarditis	DUE TO	
	(B) Arteriosclerosis	DUE TO	
	(C)	DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/1, 1950, to 4/15, 1950, that I last saw the deceased alive on 4/15, 1950, and that death occurred at 8 A. M., from the causes and on the date stated above.					
23A. SIGNATURE Joseph J. Fairbank, M.D.		23B. ADDRESS 441 S. Ellwood Ave		23C. DATE SIGNED 4/17/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 4-19-50		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE William H. Williams, Jr.		25. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler, Inc 403 S. Wolfe Street	

APR 17 1950

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Joughy  
Elwood & Eastern Aves.

S-340

50 3548

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3548  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George H. Steele

2. DATE  
OF  
DEATH

4-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

Brynmawr 5300

D. STREET ADDRESS (If rural, give location)

3613 Kelox Road

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 17, 1897

9. AGE (In years  
last birthday)

52 yrs

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Bank Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Safe Deposit &amp; Trust

11. BIRTHPLACE (State or foreign country)

Co Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert Steele

14. MOTHER'S MAIDEN NAME

Mary Higginson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War I

16. SOCIAL  
SECURITY NO.

215-05-9823

17. INFORMANT

ADDRESS

Mrs. Elizabeth H. Steele, 3613 Kelox Road

1B.

443 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebrovascular accident

INTERVAL BETWEEN  
ONSET AND DEATH

21 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiovascular Dis.

5 yrs

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 4-9, 1950 to 4-16, 1950 that I last saw the  
deceased alive on 4-16, 1950, and that death occurred at 5:20 P. M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Holloway

23B. ADDRESS

Redwood &amp; Penn Sts.

23C. DATE SIGNED

4-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 19, 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

4510 Liberty  
Heights Ave.

APR 17 1950

2668V

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE STATE OF TEXAS

COUNTY OF DALLAS

WITNESSETH THAT

THE FOREGOING

IS A TRUE AND CORRECT

STATEMENT OF

THE FACTS

AS THE SAME

APPEAR FROM

THE RECORDS

OF THE

COUNTY OF

DALLAS

THIS 10TH DAY OF

APRIL 1900

AT DALLAS

TEXAS

NOTARY PUBLIC

IN AND FOR

THE STATE OF

TEXAS

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3549  
Registered No.

BIRTH NO.

1. NAME OF DECEASED **JOHANNES KONRAD UHLIG**  
(Type or Print) *Johannes Konrad Uhlig*2. DATE OF DEATH *April 16, 1950*3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Maryland* B. COUNTYB. FULL NAME OF HOSPITAL OR INSTITUTION  
*The Union Memorial Hospital*C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 27-10*c. Length of stay in Baltimore  
Yrs. Mos. DaysD. STREET ADDRESS (If rural, give location)  
*601 E. Arlington Ave*

5. SEX

*male*

6. COLOR OR RACE

*white*7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH

*Oct 6, 1875*

9. AGE (In years last birthday)

*74*

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Teacher*

10B. KIND OF BUSINESS OR INDUSTRY

*College*

11. BIRTHPLACE (State or foreign country)

*Germany*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Edward Uhlig*

14. MOTHER'S MAIDEN NAME

*Anna Sander*15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
*no*16. SOCIAL SECURITY NO.  
*none*17. INFORMANT ADDRESS Road  
*Mr. Charles Buck- 119 Churchwardens*18. *443X*DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Generalized Arteriosclerosis*  
DUE TO *Senile Hypertension*  
*Cardiovascular disease*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Acute Cholecystitis*

INTERVAL BETWEEN ONSET AND DEATH

*years**48 hours*

19A. DATE OF OPERATION

*4-16-50*

19B. MAJOR FINDINGS OF OPERATION

*Acute Cholecystitis*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 20*, 19*50*, to *Apr 16*, 19*50*, that I last saw the deceased alive on *Apr 16*, 19*50* and that death occurred at *4:15 pm.*, from the causes and on the date stated above.

23. SIGNATURE

*Greenleaf H. Sander*

23B. ADDRESS

*Union Memorial Hosp. Bldg.*

23C. DATE SIGNED

*4-16-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Cremation*

24B. DATE

*4/18/50*

24C. NAME OF CEMETERY OR CREMATORY

*Greenmount Cemetery*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

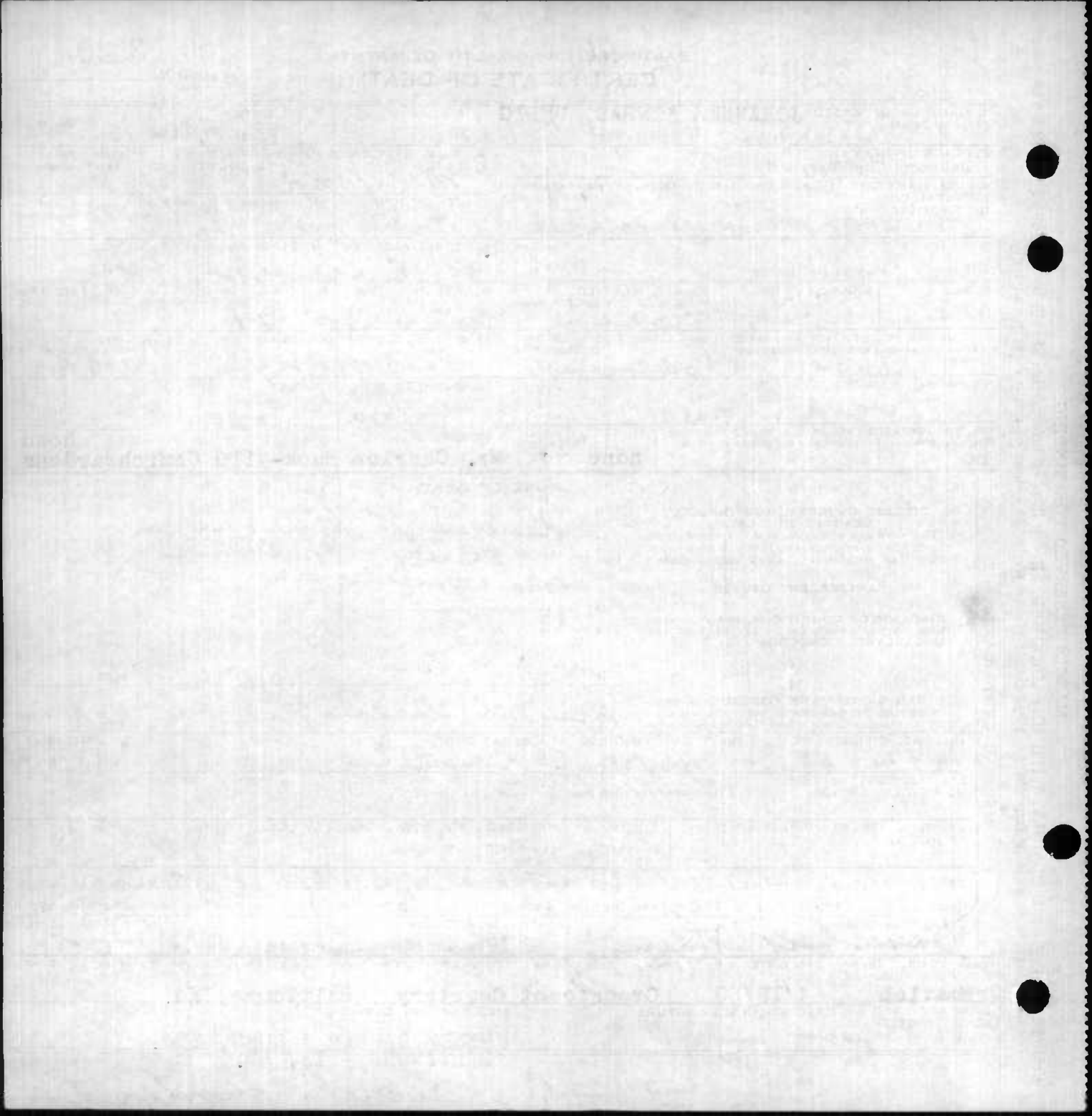
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

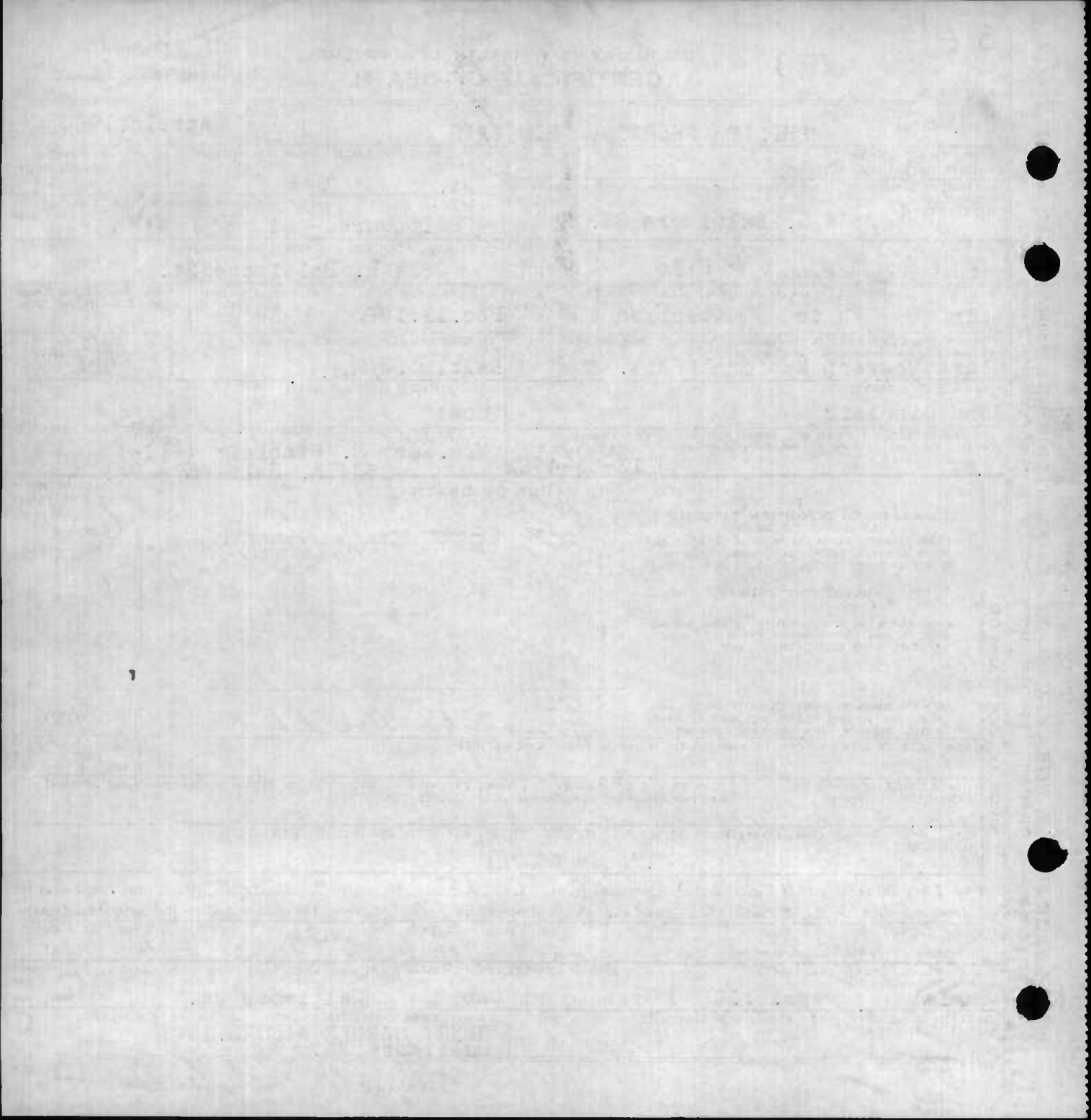
*HENRY SANDER & SONS, INC.**BALTIMORE - 13, MD.*











AB-129039

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3551

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)(GEORGE HENRY WATCHMAN)  
George Watchman2. DATE  
OF  
DEATH

4 -15-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTEBaltimore City Hospitals  
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 1739 E. Oliver  
Homeless-Baltimore City Hospitals

C. Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

--Separated married

8. DATE OF BIRTH

Feb. 9 - 1871

9. AGE (in years  
last birthday)

79

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Night Watchman

10B. KIND OF BUSINESS OR  
INDUSTRY

Garrett Bldg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Watchman

14. MOTHER'S MAIDEN NAME

Amelia Yellman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-14-7101

17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 491X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-17-1949, to 4-15-1950 that I last saw the  
deceased alive on 4-15-1950 and that death occurred at 3.15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

G. B. Crogen

M. D.

23B. ADDRESS

4940 Eastern Ave

23C. DATE SIGNED

4-16-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 18. 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

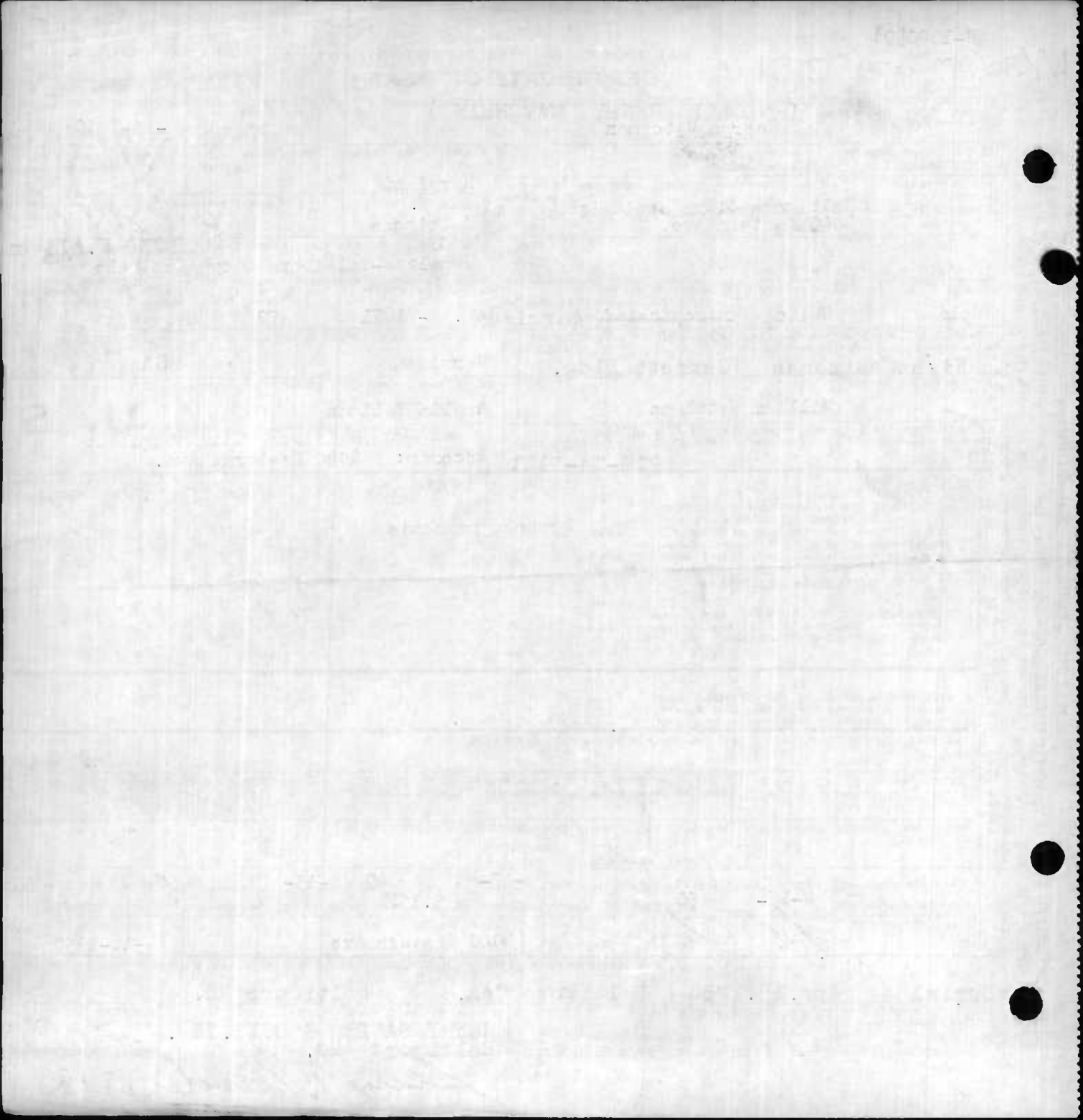
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
Baltimore Md.

ADDRESS

Henry B. Sander. 107



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3552

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Mattie Antherson2. DATE  
OF  
DEATHApril 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)1148 n. Carey st

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)Balto

D. STREET ADDRESS (If rural, give location)

1148 n. Carey st

c. Length of stay in Baltimore

60 years.

5. SEX

7

6. COLOR OR RACE

C7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)W

8. DATE OF BIRTH

Dec 18759. AGE (in years,  
last birthday)74 7510 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa12. CITIZEN OF  
WHAT COUNTRY?U. S. A.

13. FATHER'S NAME

William Wormley

14. MOTHER'S MAIDEN NAME

Martha Wormley15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Louise Johnson 1148 n. Carey st18. 420.0DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/1/41 1941, to 4/14/50 1950, that I last saw the  
deceased alive on 4/13 1950, and that death occurred at 5:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

W. S. Carson

M. D.

23B. ADDRESS

253 Conestoga

23C. DATE SIGNED

4/17/5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)Burial

24B. DATE

4-18-50

24C. NAME OF CEMETERY OR CREMATORY

London Park Nat

24D. LOCATION (City, town, or county)

and

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William W. Carson

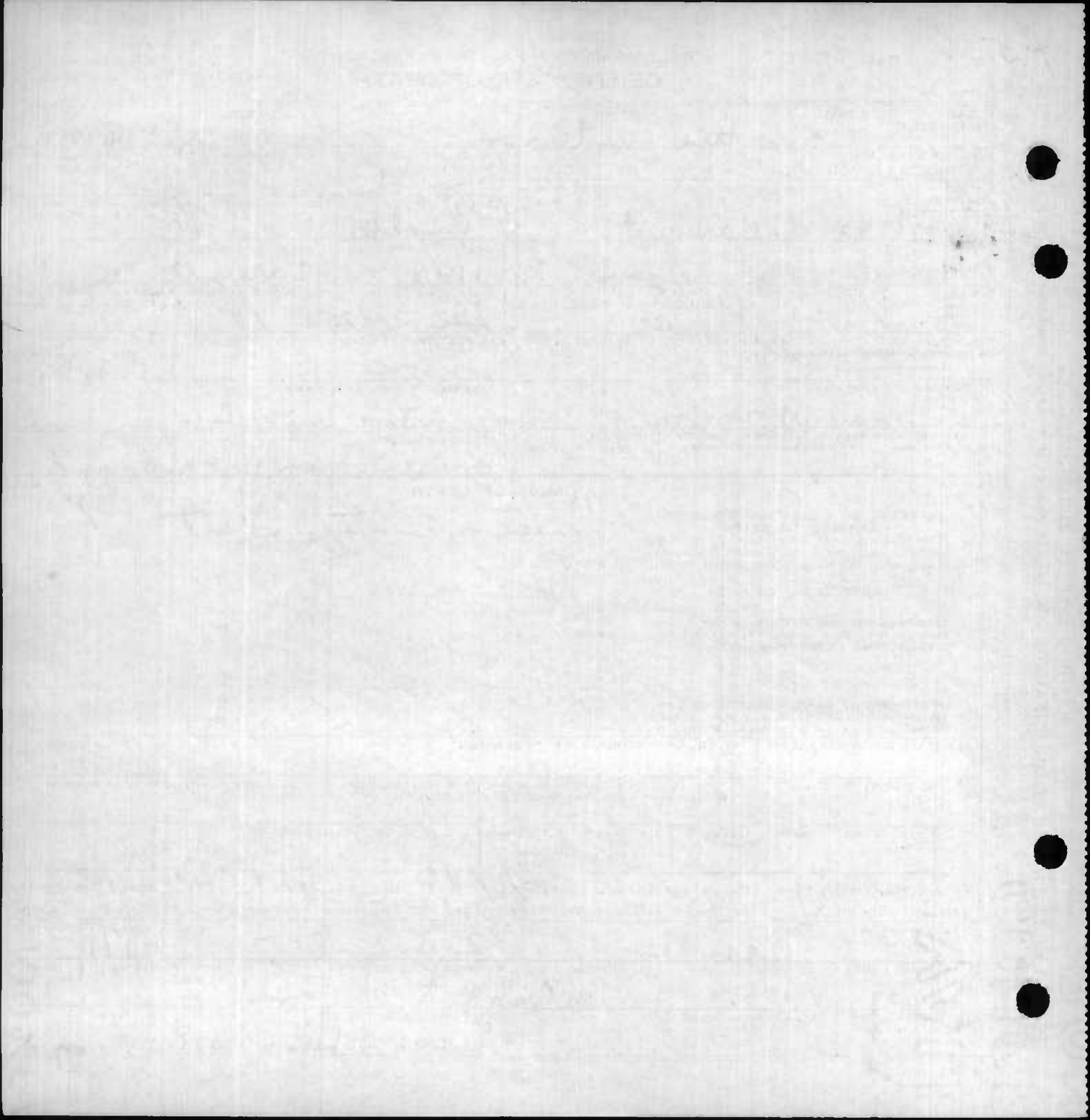
25. FUNERAL DIRECTOR

ADDRESS

George S. Kilson 1303 Presstman st

APR 15 7 50 1950

937





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3553  
Registered No.

BIRTH NO. 50 3553

1. NAME OF DECEASED  
(Type or Print) LLOYD MARSHAL GREENE2. DATE  
OF DEATH April 13, 19503. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE Maryland B. COUNTYB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Johns Hopkins Hospital

Baltimore

C. Length of stay in Baltimore

Life

D. STREET ADDRESS (If rural, give location)

1630 Miller Street

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

Aug. 13, 1884

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Porter Retired10B. KIND OF BUSINESS OR  
INDUSTRY  
Hecht Bros. Store

11. BIRTHPLACE (State or foreign country)

Baltimore County, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Lloyd Marshall Greene

14. MOTHER'S MAIDEN NAME

Melonia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
No16. SOCIAL  
SECURITY NO.  
219-03-0487

17. INFORMANT

ADDRESS

Joseph Green, 1200 Waldo Ct.

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary Tuberculosis  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

A. J. McCafferty

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
April 14, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

April 17, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

A. A. County, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Roberta Elliott &amp; Daughter

127

CERTIFICATE OF DEATH

ALBANY, N. Y. DECEMBER 1912

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)*Frank Reed*2. DATE  
OF  
DEATH*April 15 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*1711 E. Chase St*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*1711 E. Chase St*

c. Length of stay in Baltimore

*40 yrs.*

5. SEX

*Male*

6. COLOR OR RACE

*Col.*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED, (Specify)*Married*

8. DATE OF BIRTH

*July 17, 1885*9. AGE (in years  
last birthday)*64*10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Cruise Operator*10B. KIND OF BUSINESS OR  
INDUSTRY*Bethlehem Steel*

11. BIRTHPLACE (State or foreign country)

*Pa.*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Richard Reed*

14. MOTHER'S MAIDEN NAME

*Lorinda Reed*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*No*16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Bessie Reed - 1711 Chase St*18. *331X*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Cerebral Hemorrhage*  
DUE TO*2 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Generalized Arterio-sclerosis*  
DUE TO*2 yrs*

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.*Chronic Interstitial Nephritis, Hypertensive Cardiac Disease*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan*, 1948, to *April 15*, 1950, that I last saw the  
deceased alive on *April 15*, 1950, and that death occurred at *3 P.* m., from the causes and on the date stated above.

23A. SIGNATURE

*Ralph J. Gentry*

M. D.

23B. ADDRESS

*6424 S. Monument St*

23C. DATE SIGNED

*4/16/50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

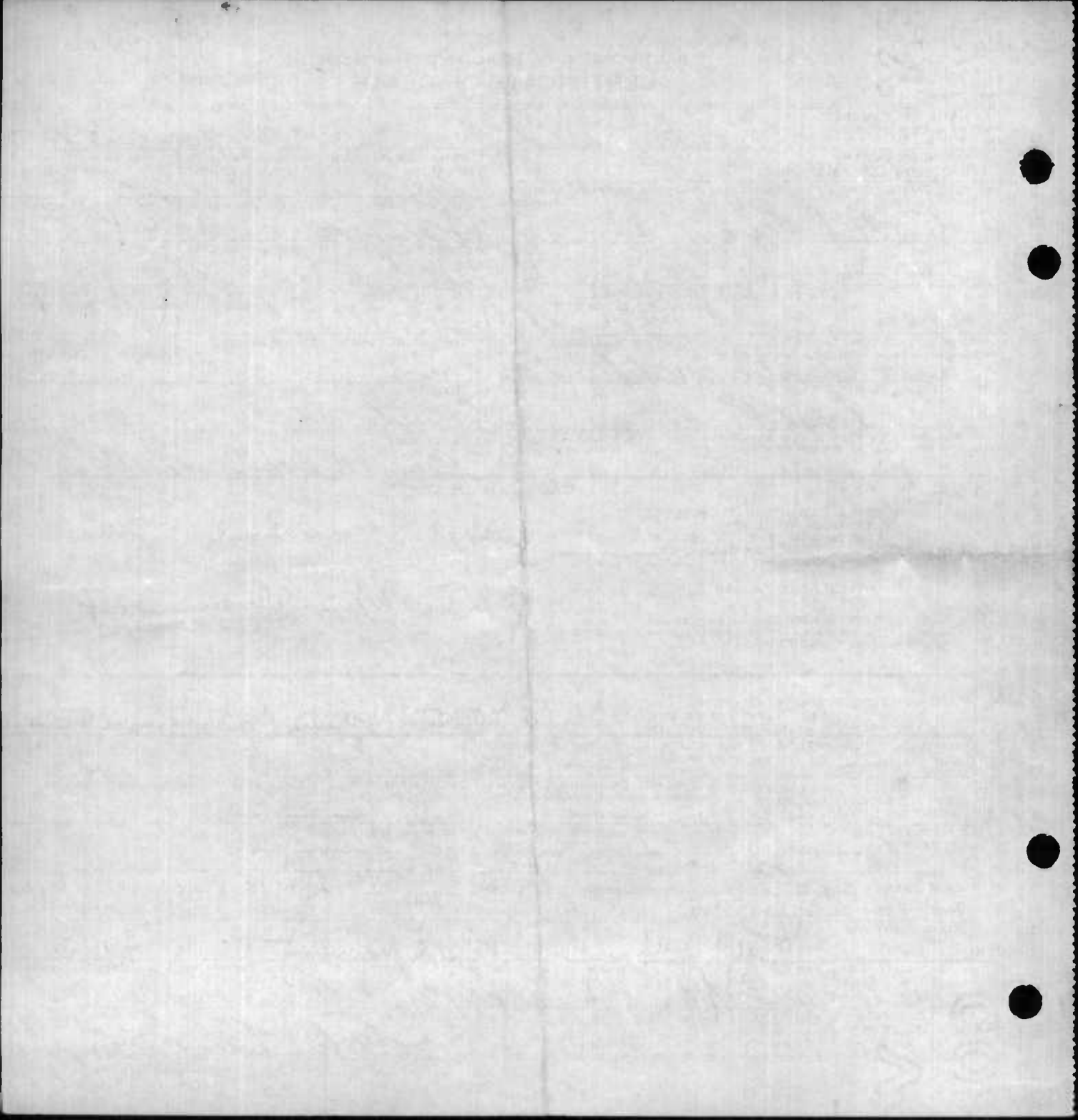
ADDRESS

*Burial**April 18/50**St. Calvary**A. A. County Md.**APR 17 1950**Ralph J. Gentry**Miss Robert A. Elliott, Daughter*

VS 150

35829

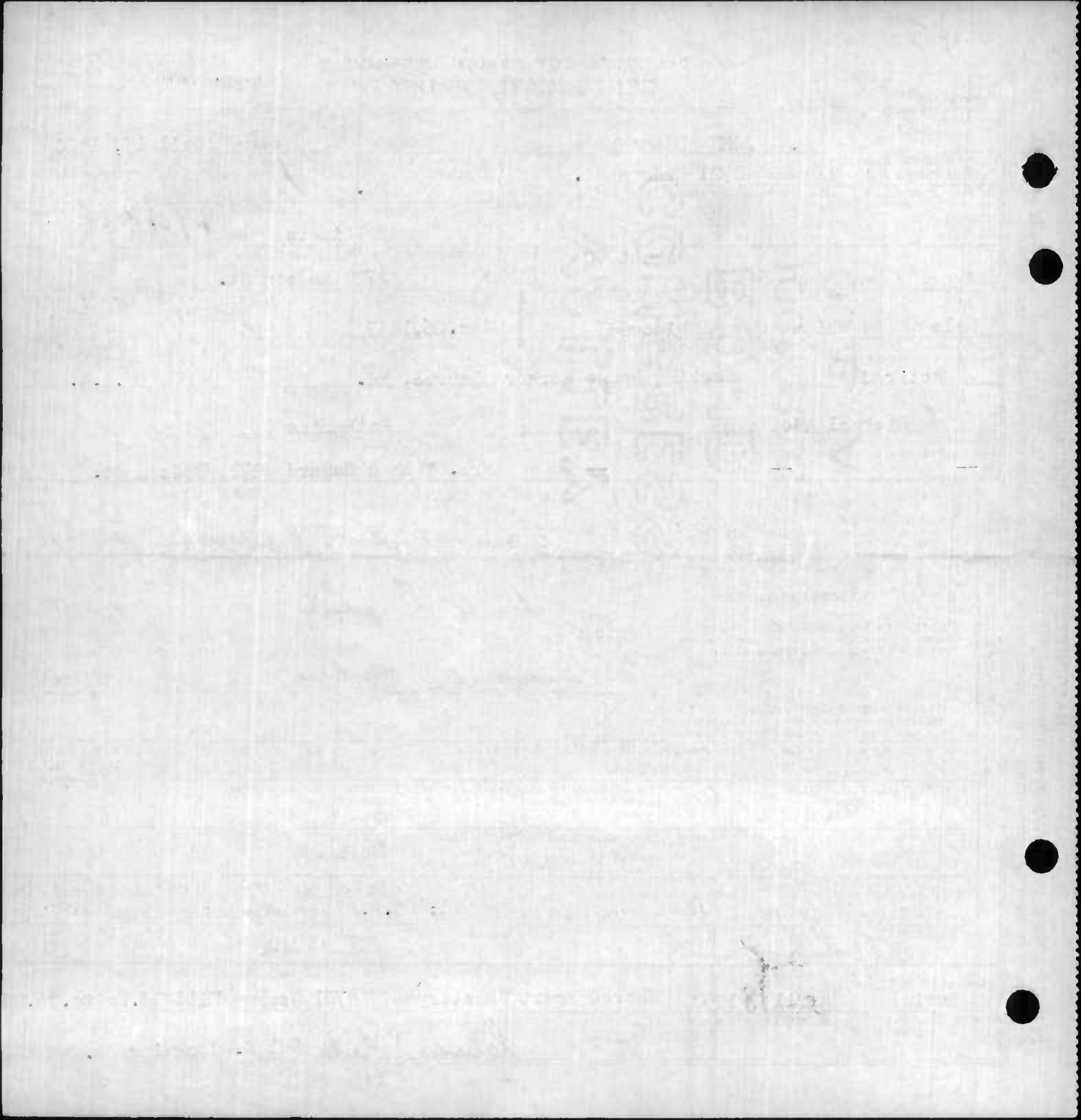
13101 297. Cadmus



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3555

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
JOHN ADELMANN		April 15, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2721 Hudson St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 00		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-04	
c. Length of stay in Baltimore About 70 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2721 Hudson St.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 26, 1857
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Packing House Worker	9. AGE (In years last birthday) 93
13. FATHER'S NAME Michael Adelmann		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		14. MOTHER'S MAIDEN NAME Katherine ?	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Thomas DeFord 2721 Hudson St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 7-11-46 4-1-50 4-5-50
19A. DATE OF OPERATION None		19B. MAJOR FINDINGS OF OPERATION None	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) None	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY None	21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> OR WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? None	
22. I hereby certify that I attended the deceased from 7-11 1946, to 4-15 1950, that I last saw the deceased alive on 4-14 1950, and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
23A. SIGNATURE E. Schimmick		23B. ADDRESS 842 8 East Ave	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE April 18 1950	
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 4701 German Hill Rd. Balto. Co. Md.	
DATE RECEIVED BY LOCAL REGISTRAR APR 17 1950		REGISTRAR'S SIGNATURE Wm. J. Williams, M.D.	
25. FUNERAL DIRECTOR Charles S. Zeiler		ADDRESS 901 S. Conkling St.	



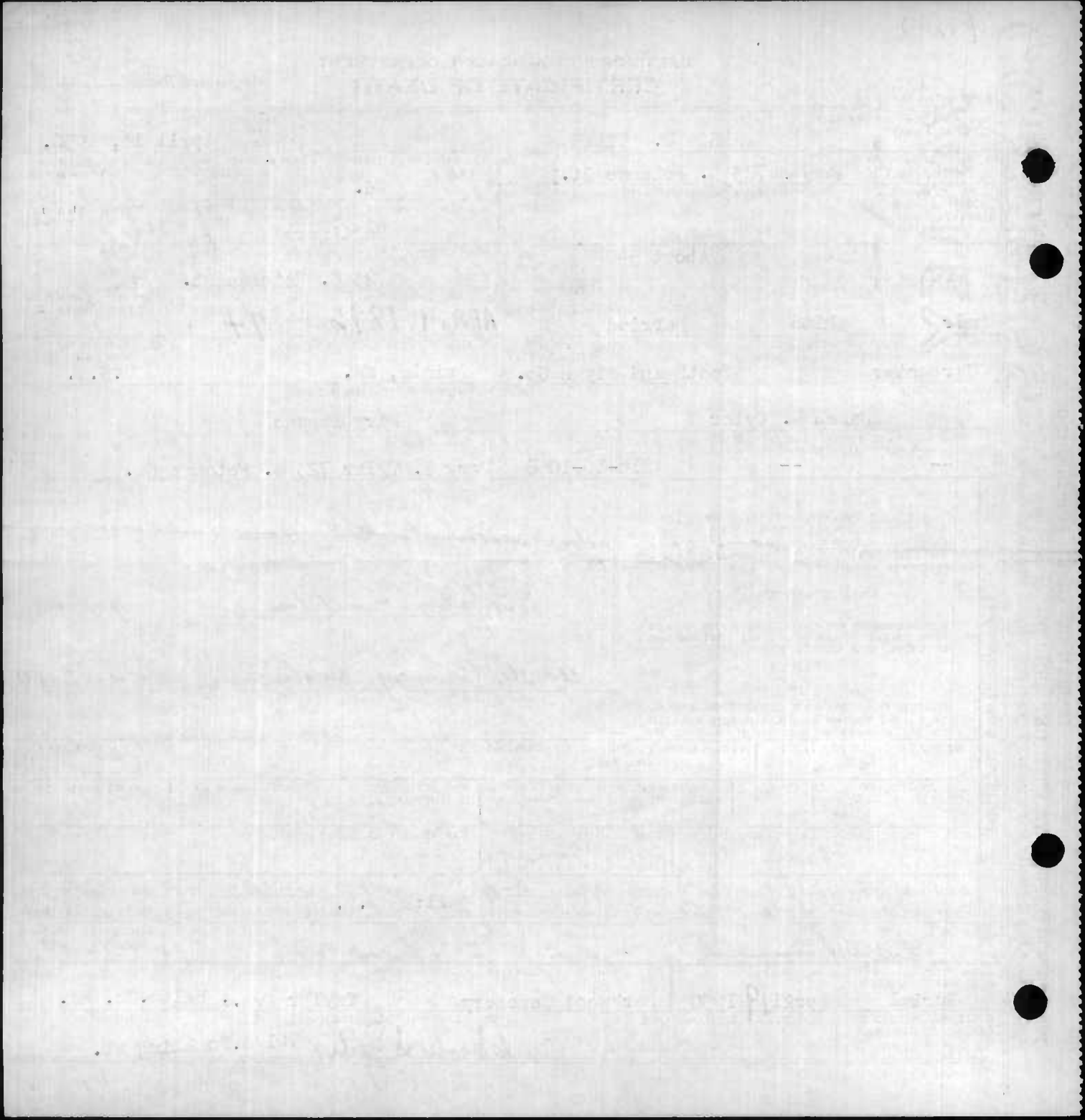


BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3556  
Registered No. \_\_\_\_\_50 3556  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES U. TYLER</b>			2. DATE OF DEATH <b>April 16, 1950.</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>723 S. Potomac St.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 1-01</b>		
c. Length of stay in Baltimore <b>About 34</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>723 S. Potomac St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>APR. 9, 1876</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Booth and Flynn Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Oriole, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James U. Tyler</b>			14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>218-10-1058</b>	17. INFORMANT ADDRESS <b>Mary I. Tyler 723 S. Potomac St.</b>		

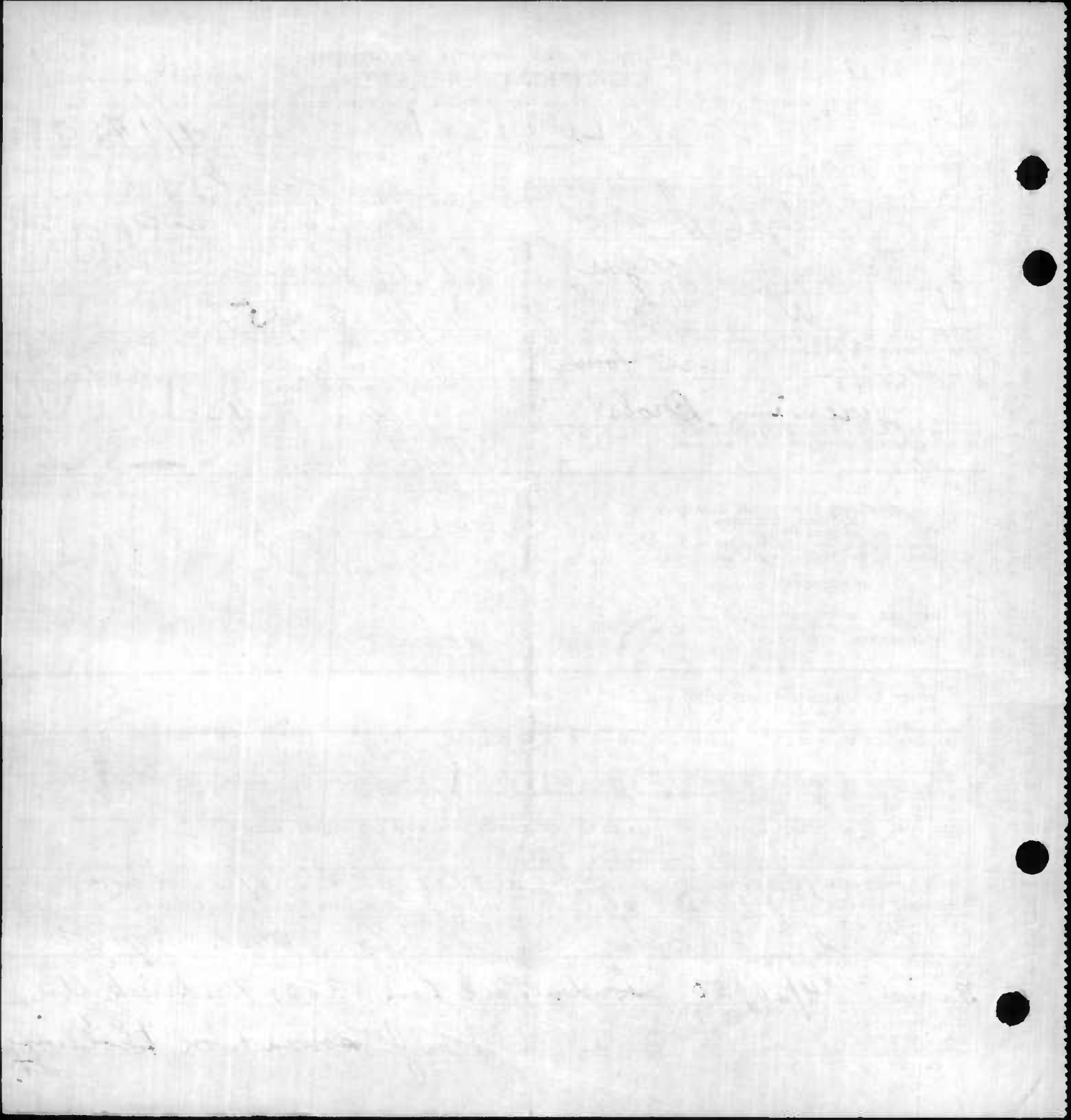
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic C. V. Disease</b> DUE TO <b>Diabetes Mellitus</b> DUE TO <b>Acute Coronary Occlusion</b>	CAUSE OF DEATH (A) <b>Arteriosclerotic C. V. Disease</b> (B) <b>Diabetes Mellitus</b> (C) <b>Acute Coronary Occlusion</b>	INTERVAL BETWEEN ONSET AND DEATH <b>9-11-49</b> <b>9-11-49</b> <b>4-16-50</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>none</b>	21B. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <b>none</b>	21C. WHERE DID INJURY OCCUR? <b>none</b>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I attended the deceased from <b>9-11</b> <sup>1949</sup> to <b>4-16</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-16</b> , 19 <b>50</b> , and that death occurred at <b>11:25 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>E. Schimmek</b>		23B. ADDRESS <b>842 S. East Ave</b>		23C. DATE SIGNED <b>4-16-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 19 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Taylor Ave., Balto. Co. Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>	REGISTRAR'S SIGNATURE <b>Washington Williams, Jr.</b>	25. FUNERAL DIRECTOR <b>Charles S. Seiler</b>		ADDRESS <b>901 S. Conkling St.</b>	



W-324  
50 3557BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3557  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Bessie L. Wetzel</i>		2. DATE OF DEATH <i>4/17/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore - 305010</i>	
c. Length of stay in Baltimore <i>30 days</i>		D. STREET ADDRESS (If rural, give location) <i>1810 Harman Ave.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>9/5/1895</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	9. AGE (In years last birthday) <i>54</i>
11. FATHER'S NAME <i>Jeremiah Brobst</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		14. MOTHER'S MAIDEN NAME <i>Laura Essey</i>	
15. SOCIAL SECURITY NO.		16. INFORMANT <i>Lloyd E. Wetzel</i> ADDRESS <i>Same</i>	
18. <i>443 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Cerebral hemorrhage, with left hemiplegia</i> DUE TO (B) <i>Osteosclerotic H.C.V.D.</i> DUE TO (C) <i>?</i>	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/14, 1950</i> , to <i>4/17, 1950</i> , that I last saw the deceased alive on <i>4/17, 1950</i> , and that death occurred at <i>5:10 p.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Robert J. Krichas</i>		23B. ADDRESS <i>St. Agnes Hospital</i>	
23C. DATE SIGNED <i>4/17/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/20/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>3801 Frederick Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 17 1950</i>		REGISTRAR'S SIGNATURE <i>William J. Williams</i>	
25. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son</i>		ADDRESS <i>937 St.</i>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3558

Registered No. \_\_\_\_\_

BIRTH NO. 50 3558

1. NAME OF DECEASED (Type or Print) <b>Eugenie Catherine O'Neil</b>			2. DATE OF DEATH <b>4/16/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore, Md.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>2305 St. Paul Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>78</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>715 N. Calvert St.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Aug. 13, 1871</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>
13. FATHER'S NAME <b>John O'Neil</b>			14. MOTHER'S MAIDEN NAME <b>Sarah McCarthy</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Joseph G. Coffay Riverdale, Md.</b>		

18. <b>490X</b> CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>pneumonia, left lower lobe</b> DUE TO (A) _____				<b>2 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) _____				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>cardiac weakness</b> DUE TO (C) _____				<b>sev. yrs.</b>
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 16, 1950</b>		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>April 15</b> , 19 <b>50</b> to <b>April 16</b> , 19 <b>50</b> that I last saw the deceased alive on <b>April 16, 1950</b> and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>E. Ellsworth</b>		23B. ADDRESS <b>2431 Maryland Ave. Balb 18</b>		23C. DATE SIGNED <b>4/17/50</b>
24A. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/18/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>4/17/50</b>		REGISTRAR'S SIGNATURE <b>W. B. Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>W. B. Williams, M.D. 715 N. Calvert St.</b>

THE  
FEDERAL  
BANK  
OF  
AMERICA  
CORPORATION  
NEW YORK



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3559  
Registered No.

630  
50 3559  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>VINCENT FORD (Vincent S. Ford)</b>			2. DATE OF DEATH <b>April 15, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1485 Montpelier Street</b> <b>1416 Montpelier Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4-26-1918</b>		9. AGE (In years last birthday) <b>32 31</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FUEL OIL (R)</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF <b>U.S.A.</b>
13. FATHER'S NAME <b>Vincent P. Ford</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Sell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-8709</b>	17. INFORMANT <b>Mrs. Virginia M. Ford</b>		
None		ADDRESS <b>I-460 Montpelier St.</b>			

18. <b>E976X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of head</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21C. WHERE DID INJURY OCCUR? <b>I-460 in Baltimore City, give exact location)</b> <b>cellar at 1416 Montpelier Street</b>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 14, 1950 9.40pm.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Shot self in head with 22 cal. rifle</b>			
22. I certify that I took charge of the remains described above, held an <b>Inquiry &amp; Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>H. J. Mc Clafferty</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.		23C. DATE SIGNED <b>April 15, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-18-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Morelands Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Taylor Avenue, Balto: Co. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>		REGISTRAR'S SIGNATURE <b>George J. Ruth, Inc.</b>		25. FUNERAL DIRECTOR ADDRESS <b>George J. Ruth, Inc. - 1735 Harford Avenue</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

THE UNIVERSITY OF CHICAGO  
LIBRARY

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3560  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Rosalie Carson

2. DATE  
OF  
DEATH

4-15-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

1721 Aiken Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1721 Aiken Street

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 14, 1902

9. AGE (In years  
last birthday)

47

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

9 I

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry J. Wheatley

14. MOTHER'S MAIDEN NAME

Iris Bozman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

None

16. SOCIAL  
SECURITY NO.

216-09-9970

17. INFORMANT

ADDRESS

Mr. Paul Carson-- 1721 Aiken Street

18. 416 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Rheumatic Heart Disease*  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)   
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(C)   
DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1947 to Apr 15, 1950, that I last saw the  
deceased alive on Apr 15, 1950, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. Mendelis M. D.

23B. ADDRESS

651 N. Beutalou St

23C. DATE SIGNED

4/15/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-18-50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State)

Eastern Ave, Balto: Co. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

George J. Ruth, Inc.

25. ADDRESS

George J. Ruth, Inc. 1735 Harford Avenue

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

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STATE OF NEW YORK

DEPARTMENT OF HEALTH

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3561  
Registered No. \_\_\_\_\_50 3561  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOHN LOUIS HEBERLE, Sr.</b>			2. DATE OF DEATH <b>April 16, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pine Crest Sanitarium 600 S. Chapel Gate Lane</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>1516 Baldwin St.</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 19, 1874</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lather</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Building Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>			13. FATHER'S NAME <b>John Louis Haberle</b>		
14. MOTHER'S MAIDEN NAME <b>?</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>no</b>			17. INFORMANT ADDRESS <b>Mr. William Heberle 3855 Quarry Ave.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION, ARTERIOSCLEROTIC</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arterio-sclerosis</b>			DUE TO <b>?</b> years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PARALYSIS AGITANS</b>			DUE TO <b>3 YEARS</b>		
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 1, 1948</b> , to <b>April 16, 1950</b> , that I last saw the deceased alive on <b>April 15, 1950</b> , and that death occurred at <b>5:10 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William H. Borden</b>		23B. ADDRESS <b>2030 W. Fayette St.</b>		23C. DATE SIGNED <b>4/16/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/19/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Hampden, Balto., Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Dr. J. J. Lickner 937 Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>		REGISTRAR'S SIGNATURE <b>William H. Borden</b>			

RECEIVED BY THE UNITED STATES

CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT

THE DECEASED WAS

NAME

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERVIEW

INTERVIEWER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERVIEW

INTERVIEWER



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3562

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emelie Schapmeier

2. DATE  
OF  
DEATH4/15/50 4<sup>30</sup> P.M.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

2603 W. Fairmount Ave

C. CITY OR TOWN

(If outside corporate limits, write R.U.M. and give township)

Balto

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2603 W. Fairmount Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

B. DATE OF BIRTH

4/22/1874

9. AGE (in years  
last birthday)

75

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

Norst

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Albert Schapmeier 2603 W. Fairmount Ave

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Arteriosclerosis, generalized 3 1/2 yrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 15, 1946, to April 15, 1950, that I last saw the deceased alive on April 15, 1950, and that death occurred at 4<sup>30</sup> P.M., from the causes and on the date stated above.

23A. SIGNATURE

Gilbert E. Rudman

M. D.

23B. ADDRESS

2517 W. Balto. St.

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/18/50

24C. NAME OF CEMETERY OR CREMATORY

Western

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

H. E. D. O. S. S.

25. FUNERAL DIRECTOR

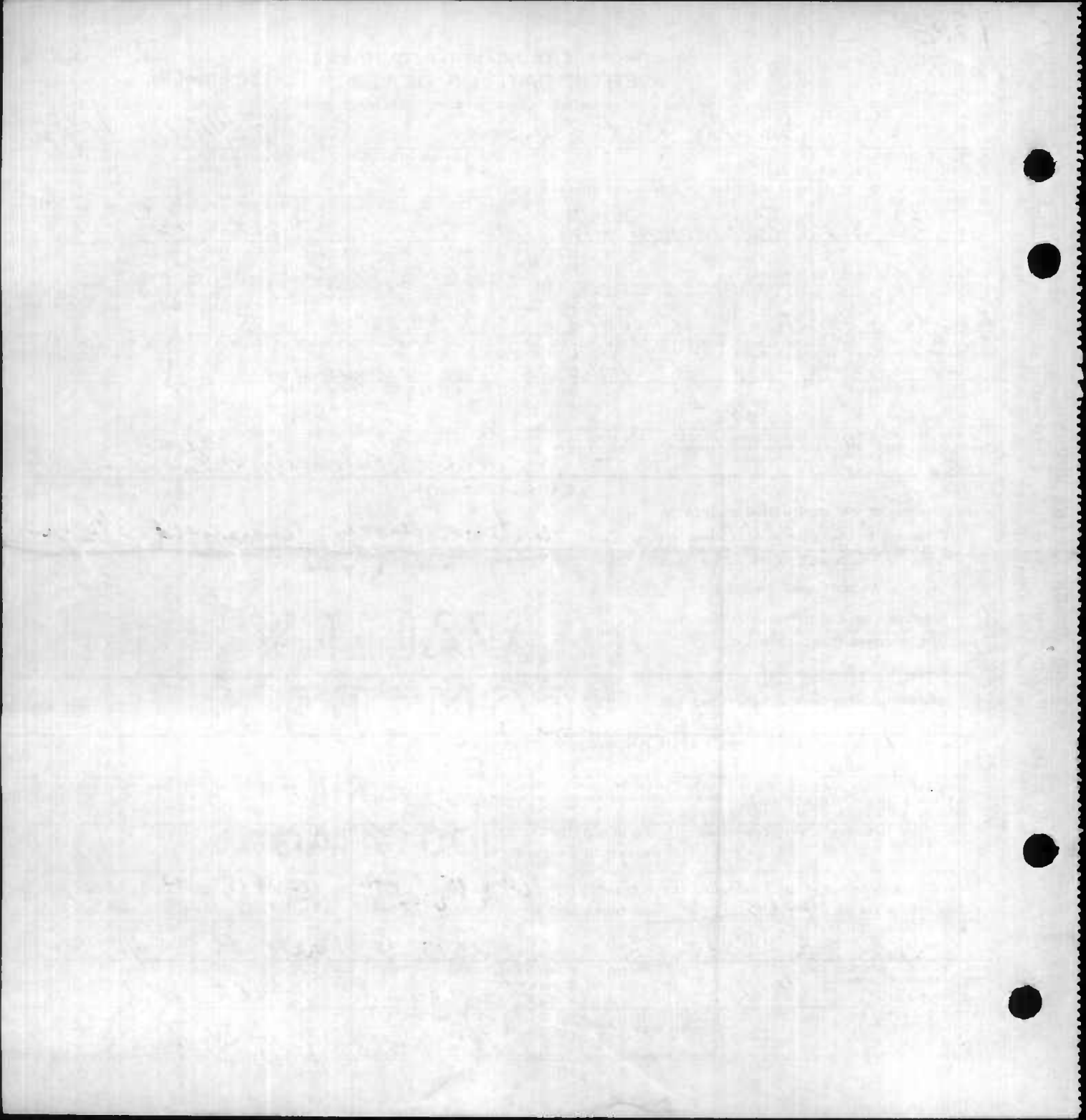
ADDRESS

Wm Cook Inc. 1217 St. Paul St.

APR 17 1950

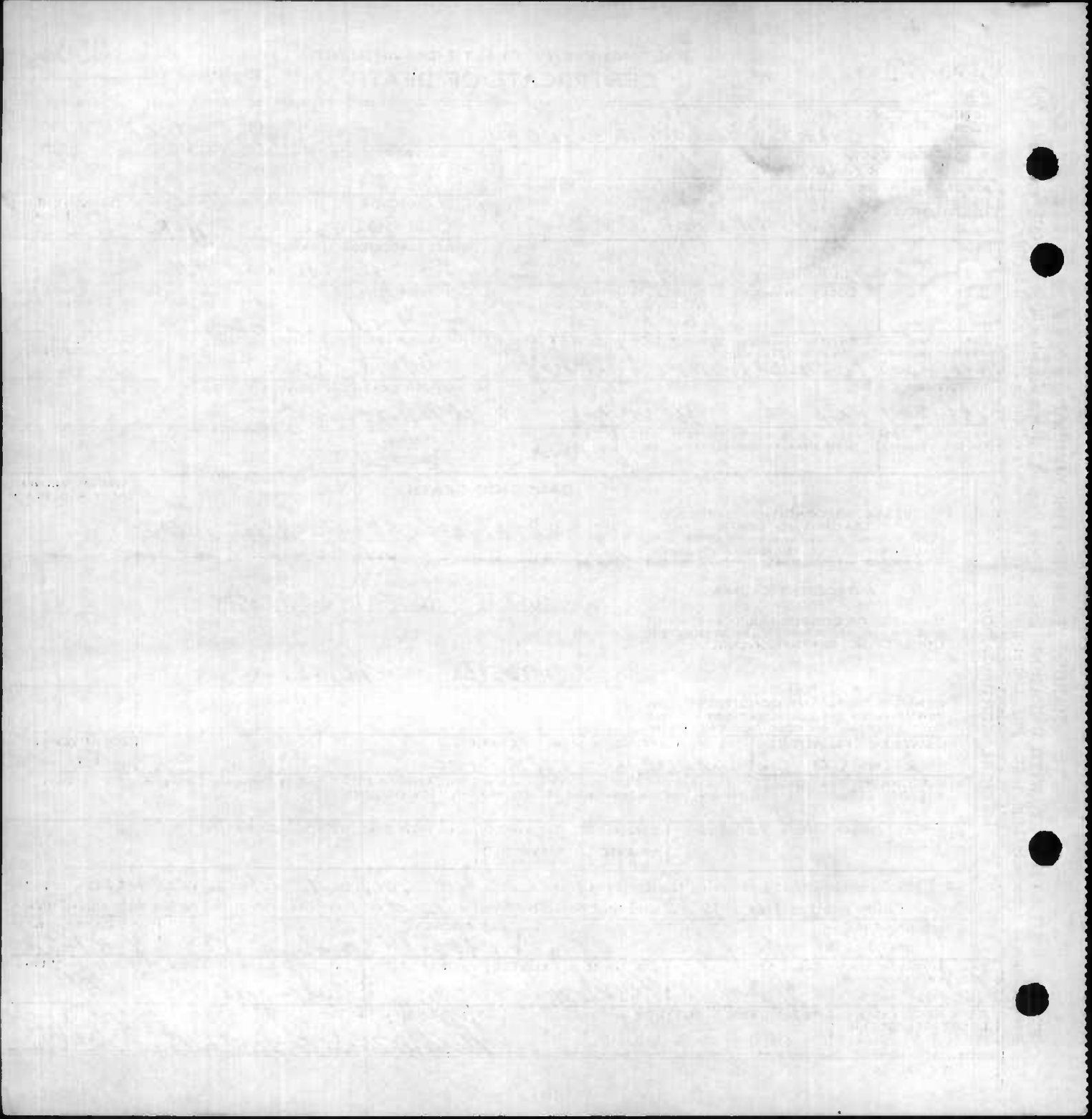
VS 150

97



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3563

BIRTH NO. <u>525</u> <u>50 3563</u>		1. NAME OF DECEASED (Type or Print) <u>CHARLES VALENTINE DUNCAN</u>		2. DATE OF DEATH <u>4-17-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH'S HOSP</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTO.</u>			
c. Length of stay in Baltimore <u>72</u> Yrs. <u>72</u> Mos. <u>72</u> Days		D. STREET ADDRESS (If rural, give location) <u>941 N. CENTRAL AVE.</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>7-24-77</u>	9. AGE (In years last birthday) <u>72</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK-CONFECTIONERY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STORE (GROCERY)</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>VALENTINA DUNCAN</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>W</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PATIENT</u>	
18. <u>760 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>GENERAL ARTERIO SCLEROSIS</u> DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2-4-50</u>		19B. MAJOR FINDINGS OF OPERATION <u>GANGRENE - LEFT FOOT</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-20</u> , 19 <u>49</u> , to <u>4-16</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4-16</u> , 19 <u>50</u> , and that death occurred at <u>2 A.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>J. Joseph Kiepin</u>		23B. ADDRESS <u>1400 N. Caroline St</u>		23C. DATE SIGNED <u>4-17-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/20/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moulton Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, MD</u>		25. FUNERAL DIRECTOR <u>William J. ...</u>		ADDRESS <u>1219 St Paul St</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 17 1950</u>		REGISTRAR'S SIGNATURE <u>William J. ...</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3564

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Marie Humphreys

2. DATE OF DEATH

4-16-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE Md.

B. COUNTY

Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION

Bon Secours Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

Dundalk

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

2821 Liberty Parkway, Dundalk

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

12-22-81

9. AGE (In Years last birthday)

68

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Vermont

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Mason

14. MOTHER'S MAIDEN NAME

Lorah Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

W

16. SOCIAL SECURITY NO.

17. INFORMANT

Raymond Griffin 2821 Liberty Pkwy

ADDRESS

18.

174X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Agranulocytosis

3 Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Adeno Carcinoma of Uterus

5 months

(C)

Cholecystitis

5 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4-13-1950 to 4-16-1950, that I last saw the deceased alive on 4-16-1950, and that death occurred at 2:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph R. Dolce

23B. ADDRESS

Bon Secours Hosp.

23C. DATE SIGNED

4-16-50.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

4/17/50

24C. NAME OF CEMETERY OR CREMATORY

Evergreen, Rutland Ct

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be written fully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3565

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John H PARKS</b>		2. DATE OF DEATH <b>April 16, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pinecrest Sanatorium</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. Length of stay in Baltimore Yrs. <b>0</b> Mos. <b>0</b> Days <b>0</b>		D. STREET ADDRESS (If rural, give location) <b>533 N 27th St</b>	
7. SEX <b>Male</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	10. DATE OF BIRTH <b>Oct 17, 1878</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer, Baltimore &amp; Annapolis</b>		12. BIRTHPLACE (State or foreign country) <b>York Pa</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Sarah (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>533 N 27th St</b>	

18. <b>422-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Chronic Myocarditis and Myo - CARDIAC Degeneration, Arteriosclerotic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Generalized Arteriosclerosis</b>		DUE TO <b>?</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Thrombophlebitis, chronic, left leg</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>November 7, 1948</b> to <b>April 16, 1950</b> , that I last saw the deceased alive on <b>April 15, 1950</b> , and that death occurred at <b>4:25 P.</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>Melvin W. Barclay</b>		23B. ADDRESS <b>2930 W. Fayette St</b>	
23C. DATE SIGNED <b>4/16/50</b>		23D. NAME OF CEMETERY OR CREMATORY <b>Mount Vernon</b>	
23E. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		23F. DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>	
23G. REGISTRAR'S SIGNATURE <b>William J. Williams, Jr.</b>		23H. FUNERAL DIRECTOR <b>William J. Williams, Jr.</b>	
23I. ADDRESS <b>1217 Stou</b>		23J. ADDRESS	

ADMINISTRATIVE DEPARTMENT  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Cemetery		15. Signature of Funeral Home	
16. Signature of Undertaker		17. Signature of Burial		18. Signature of Interment	
19. Signature of Burial		20. Signature of Interment		21. Signature of Burial	
22. Signature of Interment		23. Signature of Burial		24. Signature of Interment	
25. Signature of Burial		26. Signature of Interment		27. Signature of Burial	
28. Signature of Interment		29. Signature of Burial		30. Signature of Interment	
31. Signature of Burial		32. Signature of Interment		33. Signature of Burial	
34. Signature of Interment		35. Signature of Burial		36. Signature of Interment	
37. Signature of Burial		38. Signature of Interment		39. Signature of Burial	
40. Signature of Interment		41. Signature of Burial		42. Signature of Interment	
43. Signature of Burial		44. Signature of Interment		45. Signature of Burial	
46. Signature of Interment		47. Signature of Burial		48. Signature of Interment	
49. Signature of Burial		50. Signature of Interment		51. Signature of Burial	
52. Signature of Interment		53. Signature of Burial		54. Signature of Interment	
55. Signature of Burial		56. Signature of Interment		57. Signature of Burial	
58. Signature of Interment		59. Signature of Burial		60. Signature of Interment	
61. Signature of Burial		62. Signature of Interment		63. Signature of Burial	
64. Signature of Interment		65. Signature of Burial		66. Signature of Interment	
67. Signature of Burial		68. Signature of Interment		69. Signature of Burial	
70. Signature of Interment		71. Signature of Burial		72. Signature of Interment	
73. Signature of Burial		74. Signature of Interment		75. Signature of Burial	
76. Signature of Interment		77. Signature of Burial		78. Signature of Interment	
79. Signature of Burial		80. Signature of Interment		81. Signature of Burial	
82. Signature of Interment		83. Signature of Burial		84. Signature of Interment	
85. Signature of Burial		86. Signature of Interment		87. Signature of Burial	
88. Signature of Interment		89. Signature of Burial		90. Signature of Interment	
91. Signature of Burial		92. Signature of Interment		93. Signature of Burial	
94. Signature of Interment		95. Signature of Burial		96. Signature of Interment	
97. Signature of Burial		98. Signature of Interment		99. Signature of Burial	
100. Signature of Interment		101. Signature of Burial		102. Signature of Interment	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3566  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Josephine K. Jenkins</b>			2. DATE OF DEATH <b>April 14, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2409 Orleans St.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>DO</b>			C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>life</b>			D. STREET ADDRESS (If rural, give location) <b>2409 Orleans St.</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>June 24, 1889</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Frank Schultz</b>			14. MOTHER'S MAIDEN NAME _____		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT ADDRESS <b>Mrs. Irene Dorn, dght. 2409 Orleans St.</b>		

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Cerebral Hemorrhage</b> DUE TO (B) <b>Hypertensive Cardio Vascular</b> DUE TO (C) <b>Renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>year.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 1946</b> to <b>4-14</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-14</b> , 19 <b>50</b> , and that death occurred at <b>3 p</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>William L. Feunig</b> M. D.		23B. ADDRESS <b>3025 Belair Road</b>		23C. DATE SIGNED <b>4-15-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 18, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>North Ave. &amp; Rose St. Balto. Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 17 1950</b>		REGISTRAR'S SIGNATURE <b>Theresa J. Jones</b>			



W-252

50.3567A

Reta Washington  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3567

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Reta Washington

2. DATE  
OF  
DEATH

Apr. 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

6. CITY OR TOWN (If outside corporate limits, write P.R.I. and give township)

Baltimore

c. Length of stay in Baltimore

Life

6. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Augustus Crowdy

14. MOTHER'S MAIDEN NAME

Emma.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT, ADDRESS

JOHNS HOPKINS HOSPITAL

18.

170 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma

INTERVAL BETWEEN ONSET AND DEATH

10 MOS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Carcinoma of st. heart

DUE TO

CERTIFICATION APPROVED BY

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Dr. John R. Davis

per: B. S. Fisher M.D.

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

August 1949

19B. MAJOR FINDINGS OF OPERATION

Carcinoma, st. heart

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from D.O.B. 19\_\_ to \_\_, 19\_\_, that I last saw the deceased alive on D.O.D. 19\_\_ and that death occurred at 10:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Paul C. Wilson

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4/18/50

Mt. Auburn Cemetery

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 17 1950

Reta Washington Williams

Charles H. Fisher

VS 150

To be approved

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



UNITED STATES DEPARTMENT OF HEALTH  
CENTRAL BUREAU OF VITAL STATISTICS

1942



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3568**BIRTH NO. **50 3568**

1. NAME OF DECEASED (Type or Print) <b>MURRAY J. WISCOTT</b>			2. DATE OF DEATH <b>4/15/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>WEST BALTO. GEN. HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>46</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1818 Ashburton St.</b>		
5. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 24, 1874</b>	9. AGE (in years last birthday) <b>76</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Butcher</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Joseph W. Wiscott</b>			14. MOTHER'S MAIDEN NAME <b>Georgetta Spangle</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Anna L. Wiscott 1818 Ashburton St.</b>		

18. <b>422.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>PEMPHIGOS</b> DUE TO ANTECEDENT CAUSES (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/10</b> , 19 <b>50</b> , to <b>4/15</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/15</b> , 19 <b>50</b> , and that death occurred at <b>7:25A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>[Address]</b>		23C. DATE SIGNED <b>4/15/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-18-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Immanuel Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>G. Howard Strong 3207 W. North Ave.</b>			



MARGIN RESERVED FOR BINDING

R-152

certificate to be approved ~~CERTIFICATE CORRECTED~~

4-20-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 3569

Registered No.

50 3569

1. NAME OF DECEASED (Type or Print) <b>DOROTHY D ROBINNS</b>			2. DATE OF DEATH <b>April 16 50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-06</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Maryland General Hosp</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>5504 Fair Oaks Ave #14</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug 29 1899</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>AW</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
13. FATHER'S NAME <b>Harry Davidson</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Mackas</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Leroy C. Robinns - 5504 Fair Oaks</b>	

18. <b>733 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Generalized Bilateral fracture hip 16 wk</b> DUE TO <b>Generalized osteoporosis</b> 9 mo DUE TO <b>Tuberculosis rt lung</b>		CAUSE OF DEATH <b>Generalized Bilateral fracture hip 16 wk</b> <b>Generalized osteoporosis</b> <b>Tuberculosis rt lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mo</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>					
19A. DATE OF OPERATION <b>None</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>Accident</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Home</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>Mar 4 1950 4 P. M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Slipped &amp; fell to floor</b>	
22. I hereby certify that I attended the deceased from <b>Mar 4</b> , 1950, to <b>Apr 16</b> , 1950, that I last saw the deceased alive on <b>Apr 16</b> , 1950, and that death occurred at <b>6:25 A. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Paul G. Herold</b>		23B. ADDRESS <b>Moreland General Hosp</b>		23C. DATE SIGNED <b>4/16/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-19-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park Balto Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		24E. FUNERAL DIRECTOR <b>L. J. Luck</b>		24F. ADDRESS <b>5305 Harford Road</b>	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION  
RIVER AND WATERSHED MANAGEMENT SECTION

WATER RESOURCES DIVISION  
RIVER AND WATERSHED MANAGEMENT SECTION

WATER RESOURCES DIVISION  
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RIVER AND WATERSHED MANAGEMENT SECTION

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RIVER AND WATERSHED MANAGEMENT SECTION

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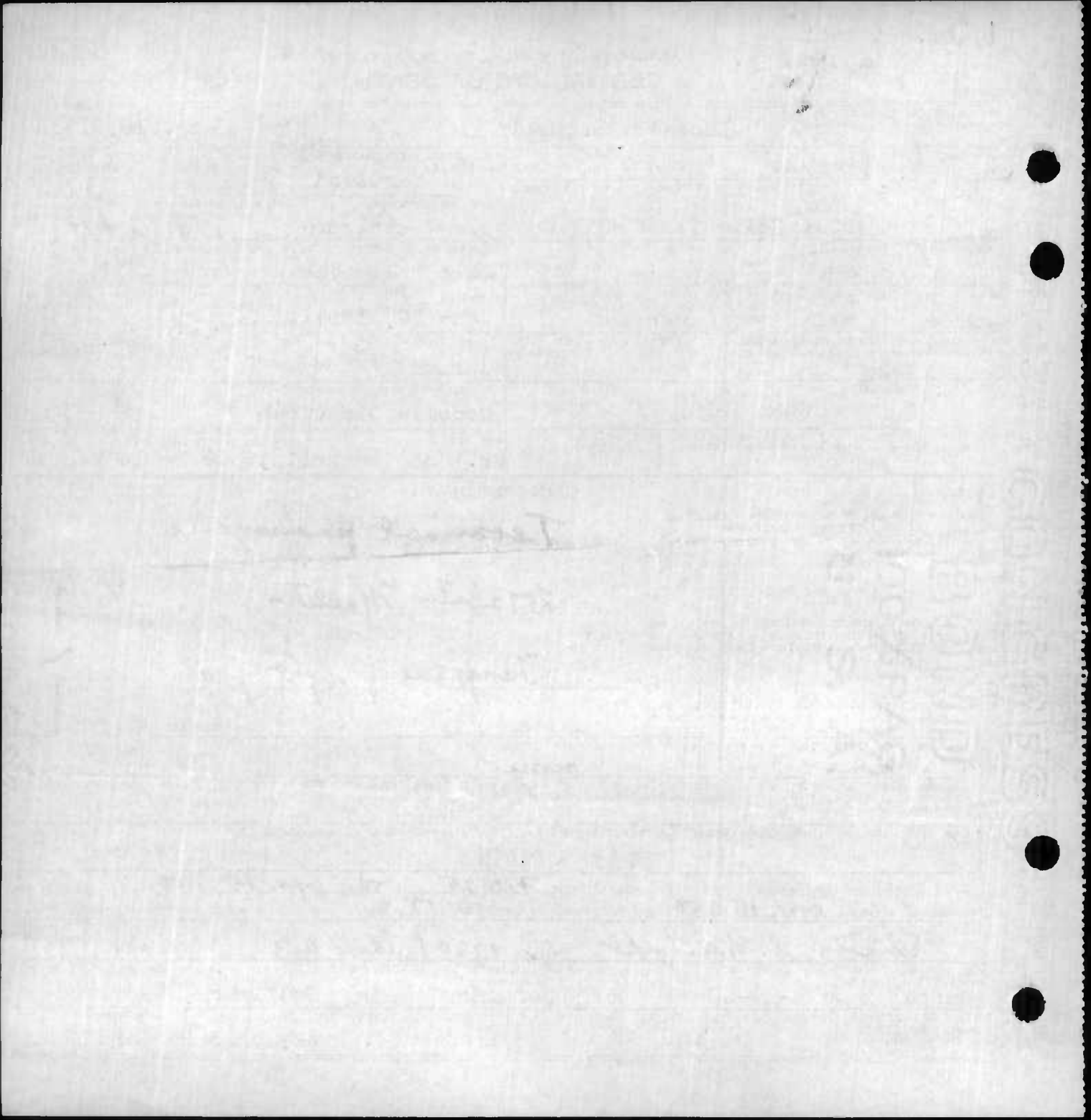
H-265 Dr. Neistadt  
1730 Linden Ave. BALTIMORE CITY HEALTH DEPARTMENT  
50 3570  
BIRTH NO. 3570  
50 3570  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly.  
The age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3570

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Lucia P. Hochrein</b>			2. DATE OF DEATH <b>Apr. 15, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>5613 Belle Vista Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-04A</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ <b>5613 Belle Vista Avenue</b>			D. STREET ADDRESS (If rural, give location)		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 29, 1867</b>		9. AGE (in years; last birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John Heil</b>			14. MOTHER'S MAIDEN NAME <b>Cecelia Diegelman</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. John Hochrein, 5613 Belle Vista</b>		
18. <b>260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Terminal pneumonia</b> (A) _____ DUE TO _____ <b>Diabetes Mellitus</b> (B) _____ DUE TO _____ <b>Gangrene of right foot.</b> (C) _____			INTERVAL BETWEEN ONSET AND DEATH <b>44 days.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Feb 25, 1950</b> , to <b>Apr. 15, 1950</b> , that I last saw the deceased alive on <b>Apr. 15, 1950</b> , and that death occurred at <b>12. m.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Charles S. Neistadt</b>		23B. ADDRESS M. D. <b>1730 Linden av</b>		23C. DATE SIGNED <b>Apr. 17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-19-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, 5305 Harford Road</b>			







MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 50 3571		1. NAME OF DECEASED (Type or Print) Walter Stopford		2. DATE OF DEATH Apr. 15 '50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) Ind.			
B. FULL NAME OF HOSPITAL OR INSTITUTION 33		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-05			
c. Length of stay in Baltimore 62 Years		D. STREET ADDRESS (If rural, give location) 6404 Atla Ave			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) A		8. DATE OF BIRTH March 1, 1867	9. AGE (In years last birthday) 82 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY T. Mullen Const. Co.		11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-01-0201 A		17. INFORMANT Alvin C. Stopford-Son-6404 Atla Ave	
18. E9160 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Pneumonia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) 2nd & 3rd° body burns			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Age of 89 years			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) ACCIDENT		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6404 Atla Ave.	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY April 1, 1950		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Smoking in bed, caught on fire	
22. I hereby certify that I attended the deceased from Apr. 1, 1950 to Apr. 15, 1950 that I last saw the deceased alive on Apr. 15, 1950 and that death occurred at m., from the causes and on the date stated above.					
23A. SIGNATURE Frederick M. Galomb		23B. ADDRESS J. H. Hospital		23C. DATE SIGNED 4/15/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/18/50		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Taylor Ave., Balto., Md.		25. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home 2601-3-5 E. Madison			
DATE RECEIVED BY LOCAL REGISTRAR APR 17 1950		REGISTRAR'S SIGNATURE		181 Street	

VS 150

N-949

VibVg

Medical Examiners Case Certificate to be approved.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3572BIRTH NO. 50 3572

1. NAME OF DECEASED (Type or Print) <u>RICHARD VETRA</u>			2. DATE OF DEATH <u>Apr 13, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>-</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home + Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 30 21-00</u>		
C. Length of stay in Baltimore <u>10</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>320 S. Poppleton St</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1 Aug 1880</u>		9. AGE (In years last birthday) <u>69 70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>George VETRA</u>			14. MOTHER'S MAIDEN NAME <u>Ella LAWRENCE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>Self</u>		

18. <u>541.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Peritonitis</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Duodenal Ulcer</u> DUE TO			<u>5 yrs</u>
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Unilateral Kidney</u>			<u>10 yrs</u>
19A. DATE OF OPERATION <u>5 Apr 50</u>	19B. MAJOR FINDINGS OF OPERATION <u>Chronic Duodenal Ulcer</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>-</u>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I hereby certify that I attended the deceased from <u>24 Mar, 1950</u> , to <u>13 Apr, 1950</u> , that I last saw the deceased alive on <u>13 Apr, 1950</u> , and that death occurred at <u>11:52 A.M.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>Richard M. Garrett</u> M. D.		23B. ADDRESS <u>Church Home + Hospo</u>	23C. DATE SIGNED <u>14 Apr 50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-19-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>St Pauls M.E. Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Deals Island, Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 17 1950</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR <u>John F. Henry Inc</u> ADDRESS <u>715 Light St.</u>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

57

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

DISPOSITION

REMARKS

SIGNATURE

DATE

TIME

PLACE

CAUSE

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

DISPOSITION

REMARKS

SIGNATURE

DATE

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3573BIRTH NO. 50 3573

1. NAME OF DECEASED (Type or Print) <u>Claude E. Buchanan</u>				2. DATE OF DEATH <u>4/16/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. Md.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>2914 S. Hanover St</u> B. COUNTY <u>25-32</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>2914 S. Hanover St</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore, Md.</u>	
c. Length of stay in Baltimore <u>7</u> Yrs. <u>None</u> Days				D. STREET ADDRESS (If rural, give location) <u>2914 S. Hanover St</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 6, 1901</u>	9. AGE (In years last birthday) <u>49</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Ship Building</u>		11. BIRTHPLACE (State or foreign country) <u>Russell Co. Va</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>James Buchanan</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Jordan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> <u>1st World</u>		16. SOCIAL SECURITY NO. <u>223-1060-66</u>		17. INFORMANT ADDRESS <u>Mike Burzaska</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <u>Hepatitis</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <u>Generalized abdominal metastases</u> DUE TO (C) <u>metastases</u>					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>3/1/50</u>		19B. MAJOR FINDINGS OF OPERATION <u>Hepatitis with generalized metastases</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/12</u> , 195 <u>9</u> to <u>4/16</u> , 195 <u>0</u> , that I last saw the deceased alive on <u>4/16</u> , 195 <u>0</u> , and that death occurred at <u>8P</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>James N. Cianos</u>		23B. ADDRESS M. D. <u>1225 N. Calvert ST.</u>		23C. DATE SIGNED <u>4/17/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>5/20/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Maran Cem.</u>	
24D. LOCATION (City, town, or county) <u>Charlottesville, Va.</u>		25. FUNERAL DIRECTOR <u>James H. Lyons</u>		ADDRESS <u>4001 Ritchie Hwy.</u>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>			

APR 17 1950 VS 150

3084W

46F







50 3574

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3574

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ARDEN Pearl PAUL L

2. DATE  
OF  
DEATH

April 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONVentnor Lodge 526 S Chapel  
Baths Lane Kensington

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS

(If rural, give location)

11 W. Washington St.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OF RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 1, 1875

9. AGE (in years,  
last birthday)

75

# Under 1 Year

Months: Days

# Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Palmira, N.Y.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel Bennett

14. MOTHER'S MARRIED NAME

Nellie Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs Robert Mac Hutton 11 W. Washington  
Kensington, Md.

ADDRESS

18. 422.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) CHRONIC Myocarditis and  
MYOCARDIAL Degeneration  
DUE TO ARTERIO SCLEROTICINTERVAL BETWEEN  
ONSET AND DEATH

2 YEARS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Generalize Arteriosclerosis

3 YEARS

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1948, to April 17, 1950, that I last saw the  
deceased alive on April 17, 1950, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Melvin N. Borden

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/20/50

24C. NAME OF CEMETERY OR CREMATORY

Arlington National

24D. LOCATION (City, town, or county)

Arlington Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

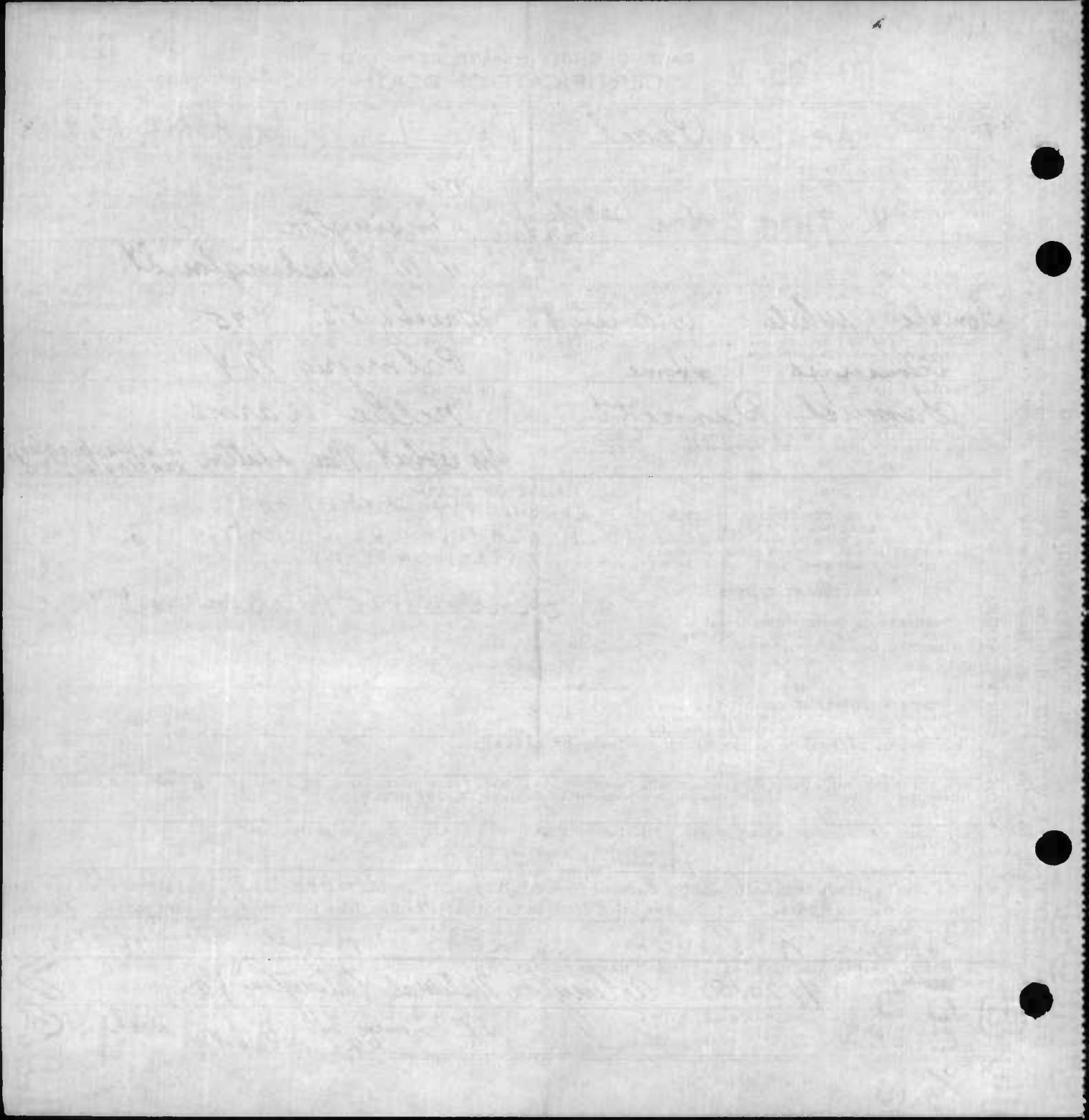
William J. Williams

25. FUNERAL DIRECTOR

W.R. Frank Jones

ADDRESS

2901 14th St. N.W. Wash. D.C.



M-245

50 3575

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3575  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Raymond Samuel James M<sup>c</sup>Lane2. DATE  
OF  
DEATH

April 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

1926 M<sup>c</sup>Culloh St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 14-03

D. STREET ADDRESS (If rural, give location)

1926 M<sup>c</sup>Culloh St.

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

May 3, 1886

9. AGE (In years last birthday)

63

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dry Cleaner

10B. KIND OF BUSINESS OR INDUSTRY

Sailor shop

11. BIRTHPLACE (State or foreign country)

Oklahoma

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

215-05-9316

17. INFORMANT

Mrs. Mary M<sup>c</sup>Lane

ADDRESS

1926 M<sup>c</sup>Culloh St.

18. H20.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Coronary occlusion

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Atherosclerotic Cardiovascular disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

21G. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 20, 1950 to April 16, 1950 that I last saw the deceased alive on April 15, 1950 and that death occurred at 2:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

J. O. Orosky M. D.

23B. ADDRESS

601 N. Monroe St.

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/16/1950

24C. NAME OF CEMETERY OR CREMATORY

Harmony Cemetery

24D. LOCATION (City, town, or county)

Wash. D. C.

DATE RECEIVED BY LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

William J. Williams, Jr.

25. FUNERAL DIRECTOR

Halland Funeral Home

ADDRESS

1651 David Hill Ave.

VS 150

Shovashy

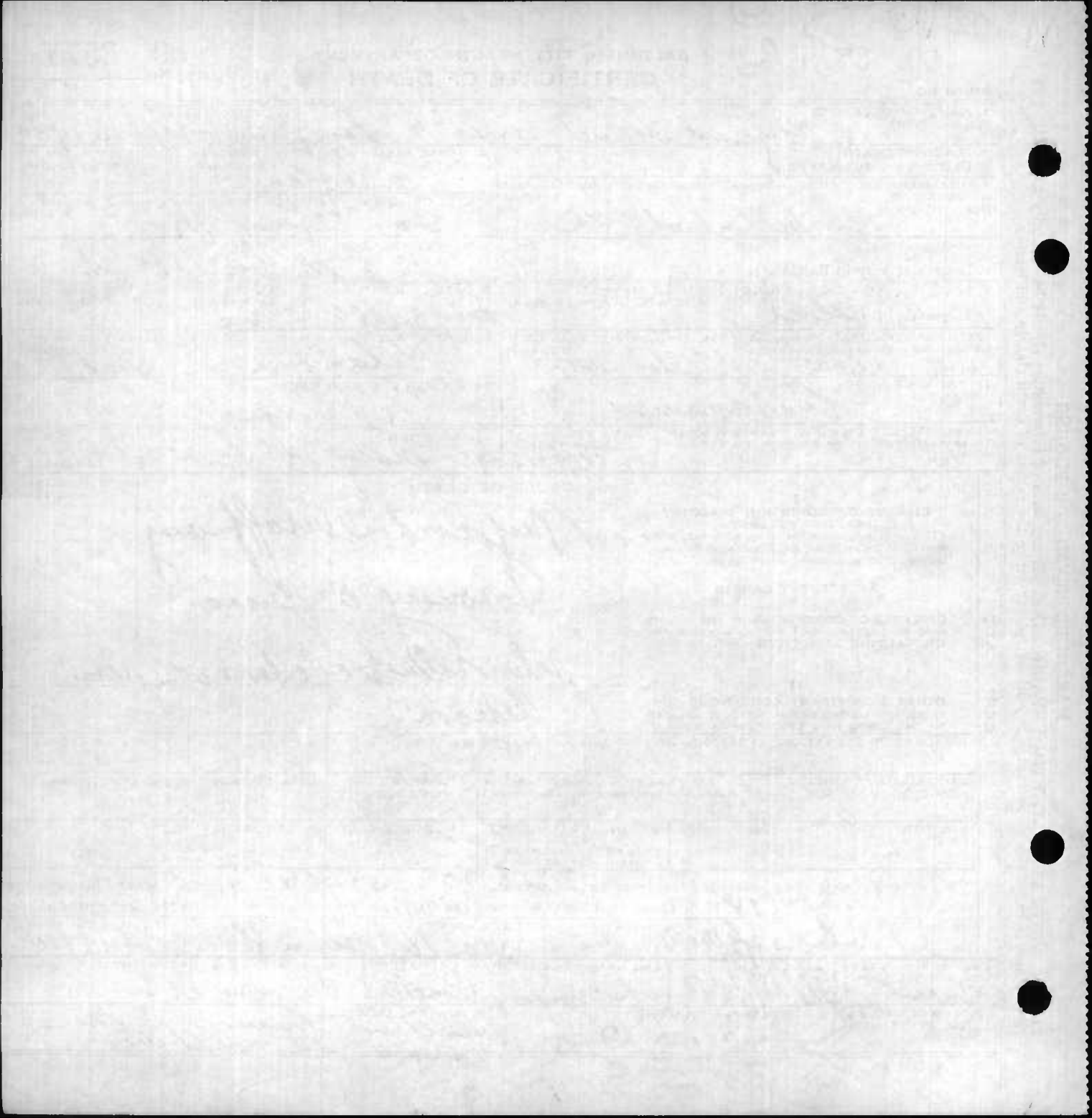
49688

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3576

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3576

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DALLAS BRANSON

2. DATE  
OF  
DEATH

16 April 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Good Samaritan Hosp  
27 N. Carey St

C. Length of stay in Baltimore

61

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug 2, 1889

9. AGE (In years,  
last birthday)

60 6 1

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Gardens

11. BIRTHPLACE (State or foreign country)

Brynmbrk. Potts Co. Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sophie Brooks

Canes Road

18. 422.1 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

Cerebral thrombosis

DUE TO

marked arteriosclerotic

(B)

cardio-vascular disease

DUE TO

with myocardial + cerebral  
degeneration

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from 25 MAR, 1950, to 16 April, 1950, that I last saw the deceased alive on 15 April, 1950, and that death occurred at 5:21 A.M., from the causes and on the date stated above.

23. SIGNATURE

Emil H. Henning Jr.

M. D.

23B. ADDRESS

601 W. Union Way

23C. DATE SIGNED

17 April 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/18/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Pleasant

24D. LOCATION (City, town, or county) (State)

Owings Mills Md

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

Washington Williams

25. FORENSIC MEDICAL EXAMINER'S ADDRESS

16 7/1 20 Owings Mills Ave



DECLARATION OF BIRTH

1. I, the undersigned, do hereby certify that the following is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

2. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

3. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

4. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

5. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

6. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

7. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

8. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

9. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.

10. I further certify that the foregoing is a true and correct copy of the original record of the birth of the child named above, as the same appears in the records of the Department of Health, Education and Welfare, State of New York, for the year 1964.



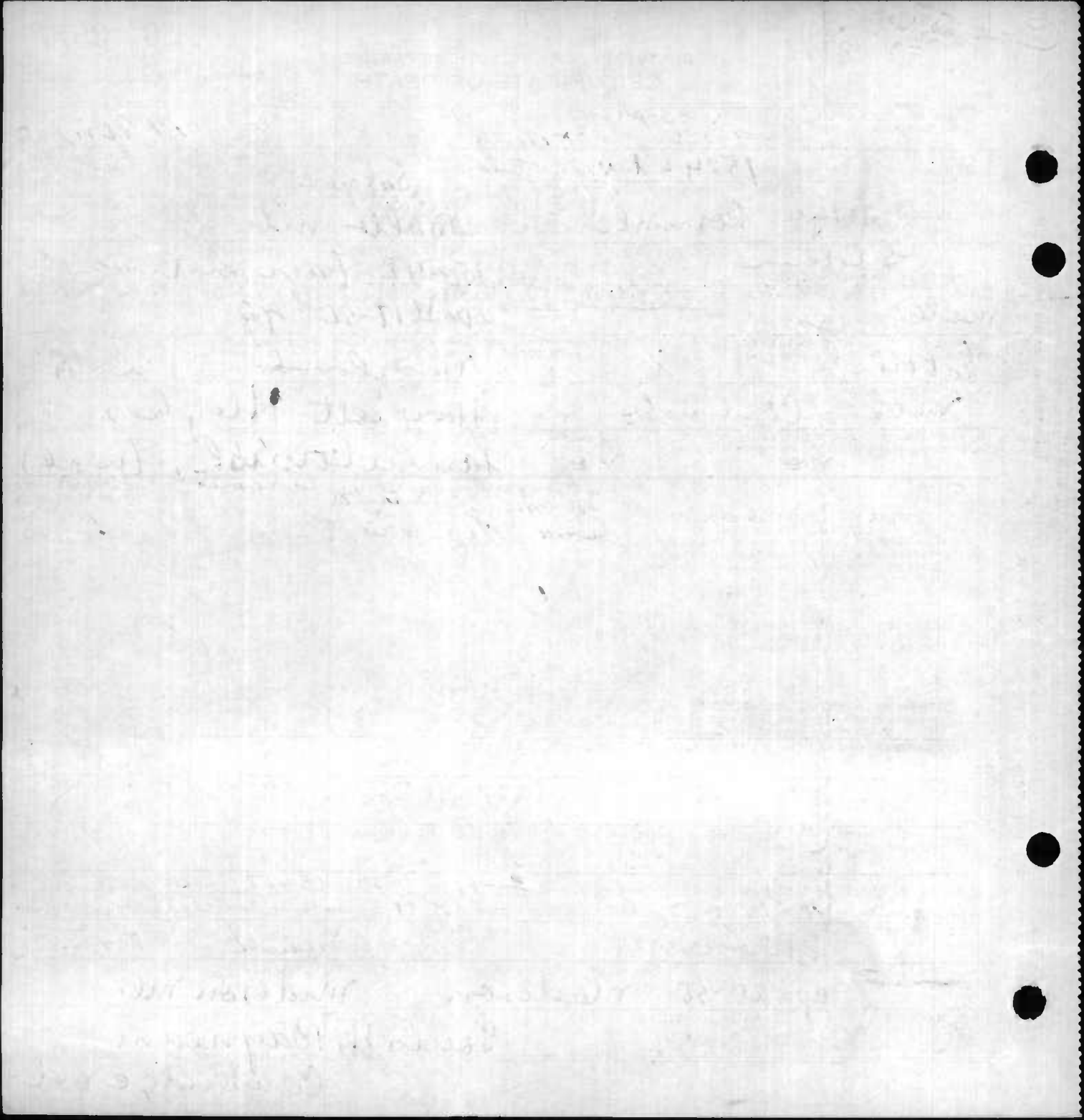
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph Cornish</i>		2. DATE OF DEATH <i>17 April 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1524 E. Fairmount Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>Sabore-</i> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Joseph Cornish</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto md 6-05</i>			
c. Length of stay in Baltimore <i>Lifetime</i>		D. STREET ADDRESS (If rural, give location) <i>1524 E. Fairmount Ave</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>April 17-50</i>	9. AGE (In years, last birthday) <i>49</i>	II Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sabore-</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Moses Cornish</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Hughes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>VE</i>		17. INFORMANT <i>Jane Cornish (wife)</i>	

18. <i>592 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic glomerulo. <del>acute</del> Nephritis</i>		CAUSE OF DEATH <i>Chronic glomerulo. <del>acute</del> Nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
DUE TO		(B)			
DUE TO		(C)			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3-17</i> , 19 <i>50</i> , to <i>3-17</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>14 Apr</i> , 19 <i>50</i> , and that death occurred at <i>8 A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>A. O. Survell</i>		23B. ADDRESS <i>121 Airpark</i>		23C. DATE SIGNED <i>4-17-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>Apr 20-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Madison</i>	
24D. LOCATION (City, town, or county) (State) <i>Madison Md.</i>		25. FUNERAL DIRECTOR <i>Louis H. Bayne</i>		ADDRESS <i>131 B Cambridge Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 18 1950</i>		REGISTRAR'S SIGNATURE <i>William Williams</i>			



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MAX HYRACH

2. DATE  
OF  
DEATH

4-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

3810 Dorchester Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3810 Dorchester Road

c. Length of stay in Baltimore

45

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (in years,

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

A. J. Bellig 3812 Dorchester Rd

18.

260 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

10 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis

DUE TO

12 years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Diabetes mellitus

DUE TO

30 years.

Nephrosclerosis

3-5 years.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 13, 1941, to April 17, 1950, that I last saw the deceased alive on April 16, 1950, and that death occurred at 1:54 p. m., from the causes and on the date stated above.

23A. SIGNATURE

A. A. Simon

M. D.

23B. ADDRESS

Temple Gardens apt.

23C. DATE SIGNED

4-17-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

M. J. Williams, M.D.

Jack Lewis, Inc. 2100 Eutan Rd

Silver  
Temple Gardens

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3579

BIRTH NO. 50 3579

1. NAME OF DECEASED (Type or Print) <b>JACOB SUSSMAN</b>			2. DATE OF DEATH <b>4/17/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto 13-04</b>		
c. Length of stay in Baltimore <b>40</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2217 Bryant Ave</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH		9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Delicatessen</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. 9.</b>
13. FATHER'S NAME <b>Paul</b>			14. MOTHER'S MAIDEN NAME <b>Clara</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Anna Sussman - 2217 Bryant Ave</b>	

## MEDICAL CERTIFICATION

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>Congestive heart failure</b> DUE TO  (B) <b>Multiple myocardial infarcts</b> DUE TO  (C) <b>arterosclerotic heart disease</b>	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/14</b> , 19 <b>50</b> , to <b>4/17</b> , 19 <b>50</b> that I last saw the deceased alive on <b>4/17</b> , 19 <b>50</b> , and that death occurred at <b>7:30 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William Kraker</b>		23B. ADDRESS <b>Sinai Hosp.</b>		23C. DATE SIGNED <b>4/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Bury</b>		24B. DATE <b>4/18/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Herring Run</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. LOCATION (State) <b>Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Jack Lewis, Inc - 2100 Eastern Pl.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 18 1950</b>		REGISTRAR'S SIGNATURE <b>William Kraker</b>			



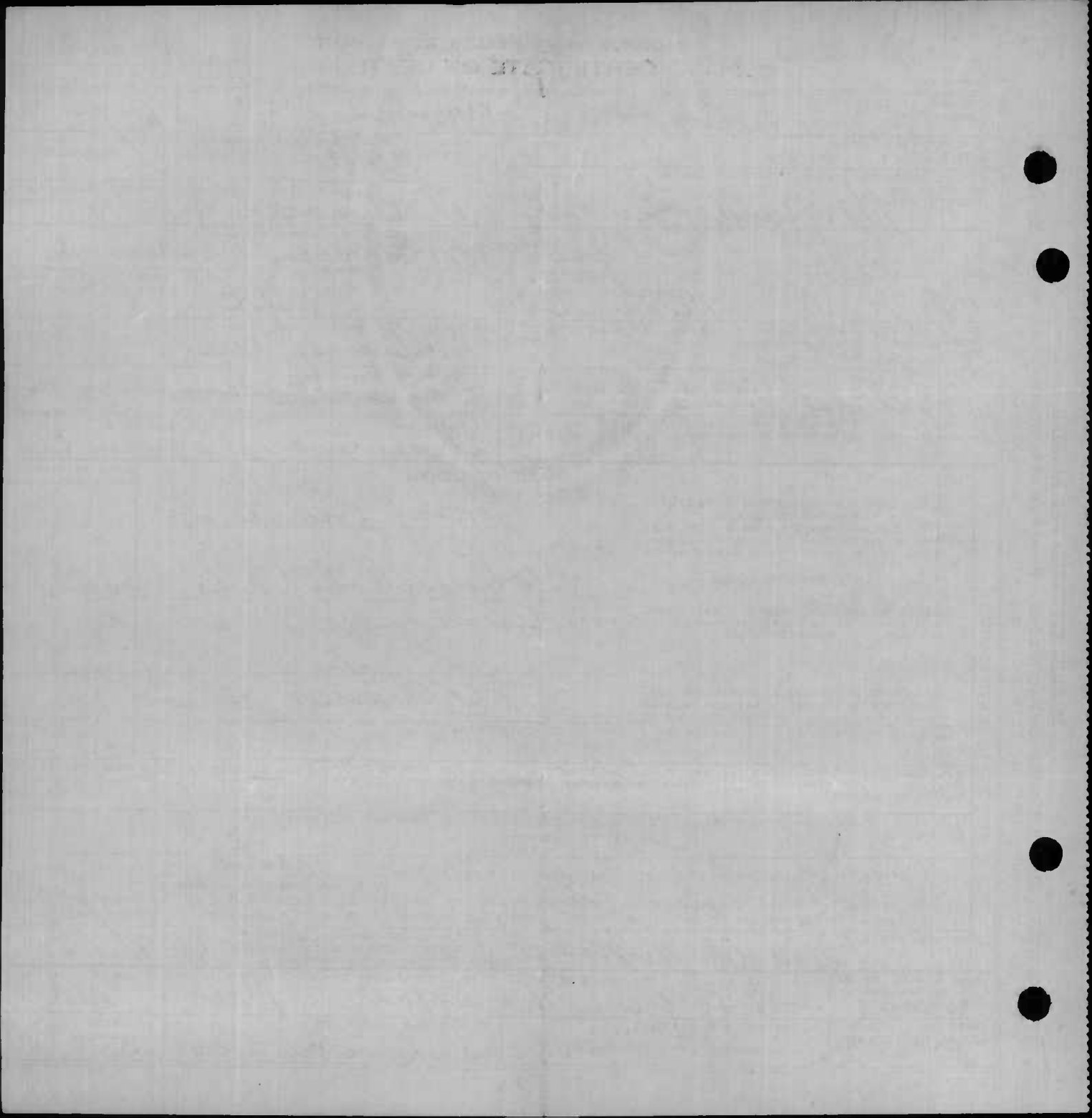




**GERBER**  
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

50 3580  
Registered No.

BIRTH NO.		50 3580	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Lillian J. Gerber		4/12/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or location)		A. STATE Md	
Maryland General		B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
Baltimore		3821 Garrison Boulevard	
c. Length of stay in Baltimore		E. DATE OF BIRTH	
Life		80	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	9. AGE (In years last birthday)
M	W	Married	80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife			Baltimore Md
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Abraham Patz		Hannah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
Abram Gerber		3821 Garrison Blvd	
18. 420.1 I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Interval between onset and death	
DUE TO		Coronary Occlusion	
ANTECEDENT CAUSES		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		Arteriosclerotic Cardio - Vascular disease	
II		DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Hypertension arterial	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
23A. SIGNATURE		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	
William T. McHugh		4/17/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		4-18-50	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Hebrew Acorn Run		Baltimore Md	
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR	
APR 18 1950		Jack Lewis Inc 2100 Sutton Pl	
REGISTRAR'S SIGNATURE		ADDRESS	
Washington Williams, M.D.			



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F-432		50 3581		BALTIMORE CITY HEALTH DEPARTMENT		50 3581	
BIRTH NO.				Registered No.			
1. NAME OF DECEASED (Type or Print) <i>Daisy Fields</i>				2. DATE OF DEATH <i>APR 16 1950</i>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Pa.</i> B. COUNTY <i>V-25</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Philadelphia</i>			
c. Length of stay in Baltimore Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <i>2121 N. 18th St.</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W.</i>		8. DATE OF BIRTH <i>1-9-00</i>	
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>50</i>		11. BIRTHPLACE (State or foreign country) <i>New Bern, N.C.</i>	
13. FATHER'S NAME <i>?</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Bryan</i>		17. ADDRESS		14. MOTHER'S MAIDEN NAME <i>Margaret Bryan</i>	
18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cerebral hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3d</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive + arteriosclerotic</i>				DUE TO <i>Cardiovascular disease.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Broncho pneumonia</i>				DUE TO <i>1 wk.</i>			
19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3-31-1950</i> to <i>4-16-1950</i> , that I last saw the deceased alive on <i>4-16-1950</i> and that death occurred at <i>6:05 PM</i> , from the causes and on the date stated above.							
23A. SIGNATURE <i>Susan Calhoun</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>4-16-50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/19/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mount Eden</i>		24D. LOCATION (City, town, or county) (State) <i>Philadelphia, Pa.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 18 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Williams, Jr.</i>		25. FUNERAL DIRECTOR <i>THE CHARLES R. LAW MORTUARY</i>		ADDRESS <i>802-04 MADISON AVENUE</i>	
VS 150		43406		802-04 MADISON AVENUE		BALTIMORE 1, MD. <i>93D</i>	



CERTIFICATE CORRECTED

4-18-50

50 3582

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)WILLIE ODESSA GARRETT DAVIDSON  
*(Odessa Davidson)*2. DATE  
OF  
DEATH

Apr. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *a 2 Woun - C*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

d. Length of stay in Baltimore

20 Yrs.

5. SEX

female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-30-17

9. AGE (In years  
last birthday)

33

H Under 1 Year  
Months DaysU Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

NURSE'S AID

10B. KIND OF BUSINESS OR  
INDUSTRY

HOSPITAL

11. BIRTHPLACE (State or foreign country)

ASHEVILLE, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS GARRETT

14. MOTHER'S MAIDEN NAME

ANNIE BEARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

239-14-2070

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

624 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Septicemia

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Peritonitis

DUE TO

2 weeks

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Intestinal Obstruction

2 weeks

Ileo-ecdominal fistula

19A. DATE OF OPERATION

March 1950

19B. MAJOR FINDINGS OF OPERATION

tubo-ovarian abscess, adhesions - partial obstruction

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/14 3:15, to 3/17, 1950, that I last saw the  
deceased alive on 3/17, 1950, and that death occurred at 7:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Lawrence R. Howard, M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

4/23/50

24C. NAME OF CEMETERY OR CREMATORY

Mount Calvary

24D. LOCATION (City, town, or county)

ASHEVILLE, N.C.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

THE CHARLES R. LAW MORTUARY

APR 18 1950

VS 150

79092

802-04 MADISON AVENUE

BALTIMORE 1, MD. 139a

CERTIFICATE OF DEATH

1912

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ARRIVAL

PLACE OF ARRIVAL



F-623

50 3583

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3583

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DAISY VIOLA FORSYTH

2. DATE  
OF  
DEATH

Apr. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

DO 319 S. Newkirk St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

319 S. Newkirk St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 7, 1886

9. AGE (in years last birthday)

63

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cutter, retinning factory

10B. KIND OF BUSINESS OR INDUSTRY

Helwig &amp; Liech

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Jenkins

14. MOTHER'S MAIDEN NAME

(Unknown) Burress

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

219-18-1354

17. INFORMANT

ADDRESS

James R. Forsyth, 319 S. Newkirk St

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/18, 1946, to 4/17, 1950, that I last saw the deceased alive on 4/15/50, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/19/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

Baltimore County, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

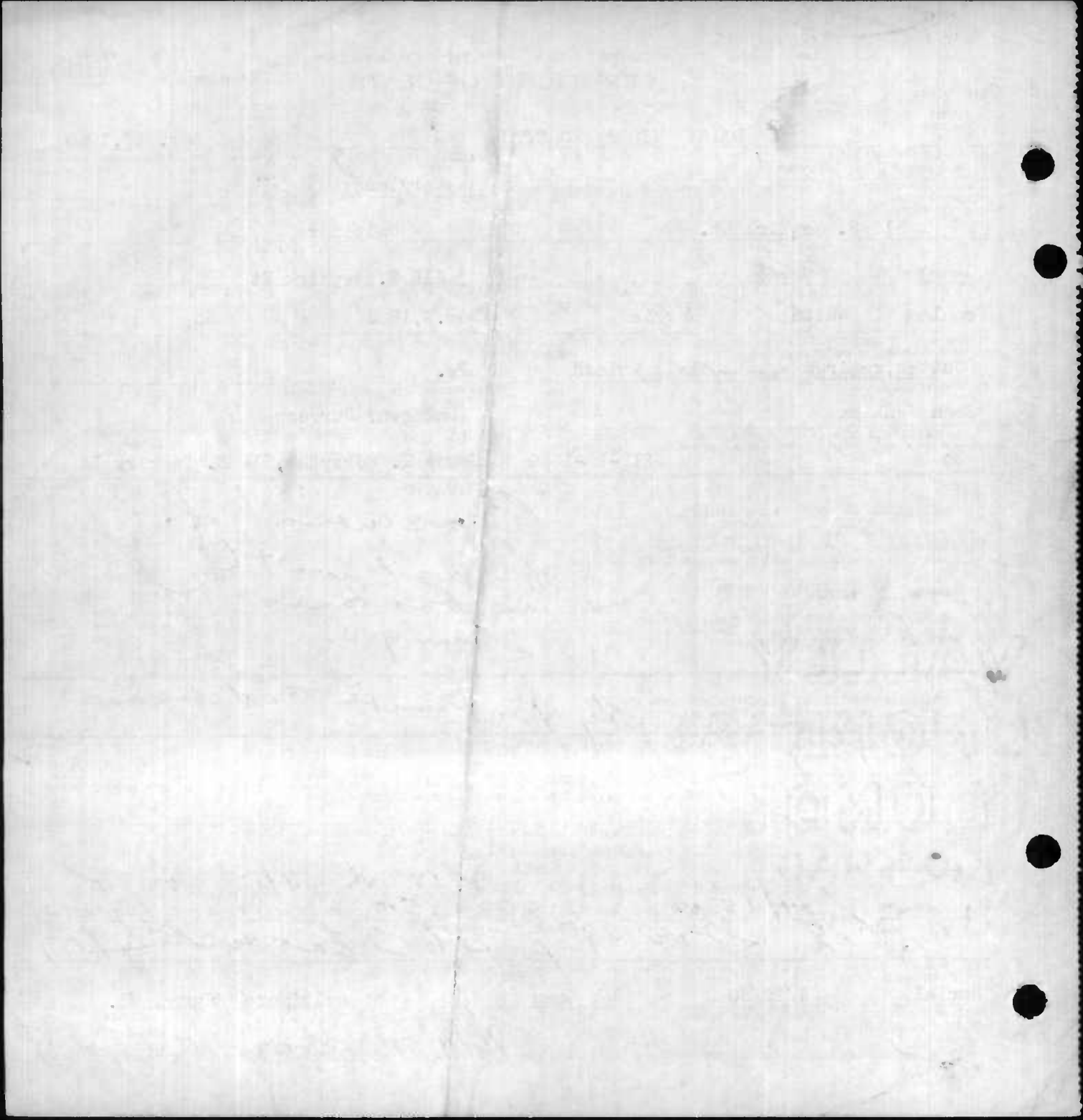
VS 150

496 X1

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



L-352

50 3584

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3584

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH LAUTENKLOS

2. DATE

OF DEATH Apr. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE  
4503 Hampnett Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4503 Hampnett Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

Feb. 1, 1869

9. AGE (In years last birthday)

81

H Under 1 Year Months Days H Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurses aid

10B. KIND OF BUSINESS OR INDUSTRY

Union Memorial Hospital

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Peter Lautenklos

14. MOTHER'S MAIDEN NAME

Barbara Reming

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.  
None

17. INFORMANT

ADDRESS

Amelia Magruder, 4503 Hampnett Ave.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease 10-15 yrs

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pneumonitis 3 weeks prior to death. Terminal Coma

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 16, 1948, to April 17, 1950 that I last saw the deceased alive on April 15, 1950, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. T. Harbold

23B. ADDRESS

4706 Harford Road

23C. DATE SIGNED

April 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/19/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

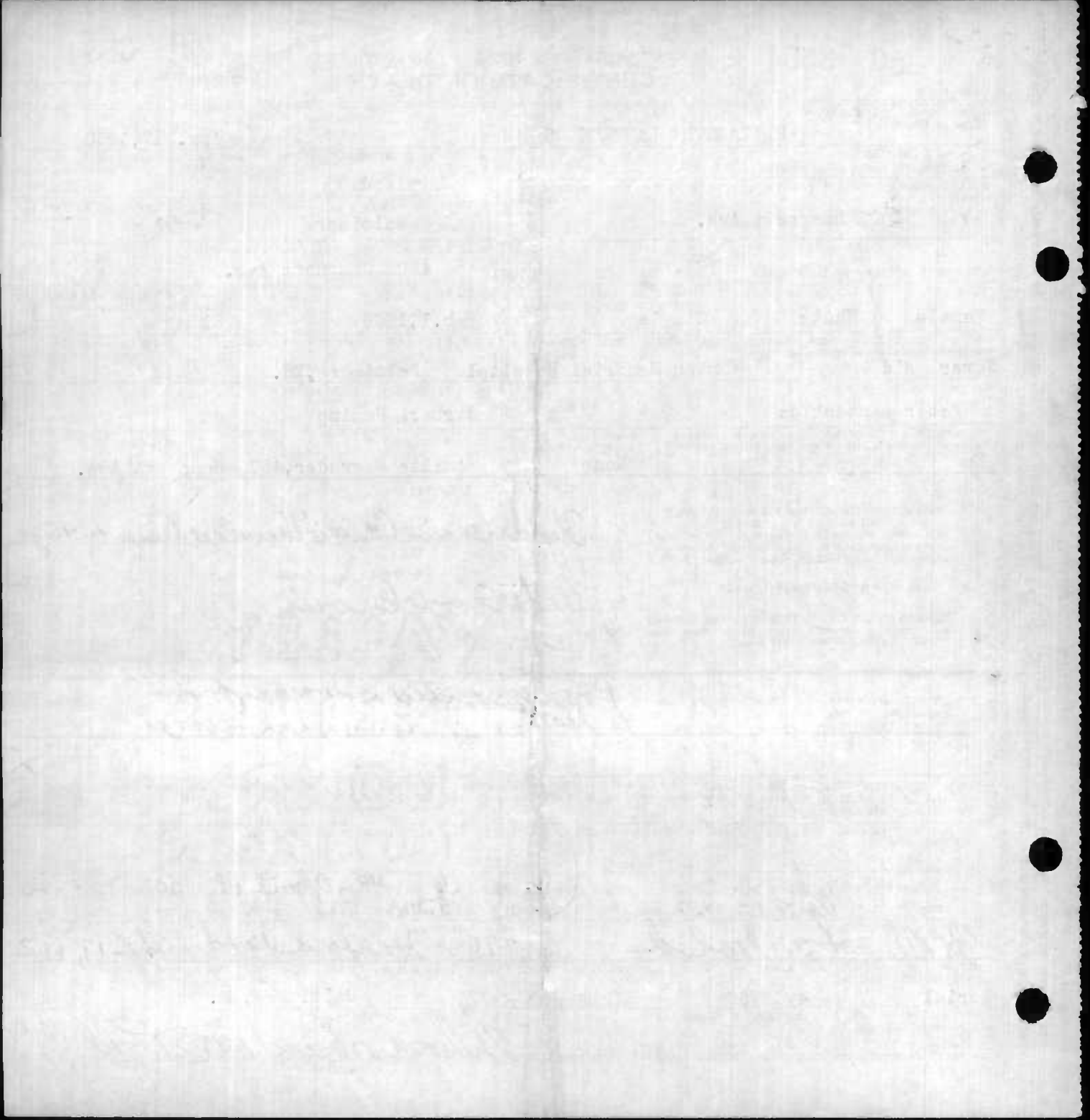
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



400

50 3585

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3585  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Barrie Duell</i>		2. DATE OF DEATH <i>4/17/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Md</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>9-09</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>704 E. Preston St</i>	
5. SEX <i>Se</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>6/9/1876</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>W. W.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	9. AGE (In years last birthday) <i>73</i>
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <i>Franklin Square Hospital</i>	

18. *153X* CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) *Metastases, Liver at Colon.*

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
(B) *Adeno Carcinoma.*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
(C)

INTERVAL BETWEEN ONSET AND DEATH  
*1 yr.*

19A. DATE OF OPERATION <i>6-49</i>		19B. MAJOR FINDINGS OF OPERATION <i>Resection Colon for Ca Colon</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <i>W. B. Barbone</i>		23B. ADDRESS <i>Franklin Square</i>		23C. DATE SIGNED <i>4/17/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>4/20/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25. FUNERAL DIRECTOR <i>William J. Williams</i>		ADDRESS <i>1217 S. Cal St</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION		MARRIAGE		MILITARY SERVICE	
PREVIOUS MARRIAGES		PREVIOUS DEATHS		PREVIOUS INMATE		PREVIOUS MENTAL		PREVIOUS PHYSICAL		PREVIOUS OTHER	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		SURVIVAL		POST-MORTEM		OTHER	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	



B500  
M M 120649 50 3586 BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 3586

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William, Bowen.

2. DATE  
OF  
DEATH

April, 17-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTEBaltimore City Hospitals.  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore.

18-03

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

891 Lemmon St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 26, 1864

9. AGE (In years  
last birthday)

85

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

On Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David, Bowen

14. MOTHER'S MAIDEN NAME

Rebecca, Porter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B.C.H. Records 4940 Eastern Ave.

18.

491X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchopneumonia RLL LLL

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Old calcified pleuritis cause unknown

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 6-22, 1948 to 4-17-50, 19, that I last saw the  
deceased alive on 4-17-50, 19, and that death occurred at 4:25 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Ave.

April 17, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4/19/50

St. Peters

Bulto. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

Wm. C. Cook Inc

1217 St. Paul St.



W256

50 3587

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3587

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marie A. Wagner

2. DATE  
OF  
DEATH

4/17/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Wells Md 27-05

D. STREET ADDRESS (If rural, give location)

6119 Sefton Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan 6<sup>th</sup> 1888

9. AGE (In years last birthday)

62 (djm)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm Fink

14. MOTHER'S MAIDEN NAME

Mary E. Schnitker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Lester F. Wagner 6119 Sefton Ave

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Hypertensive C.V. disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

D. J. Schubert

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/21/50

24C. NAME OF CEMETERY OR CREMATORY

Immanuel Lutheran

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

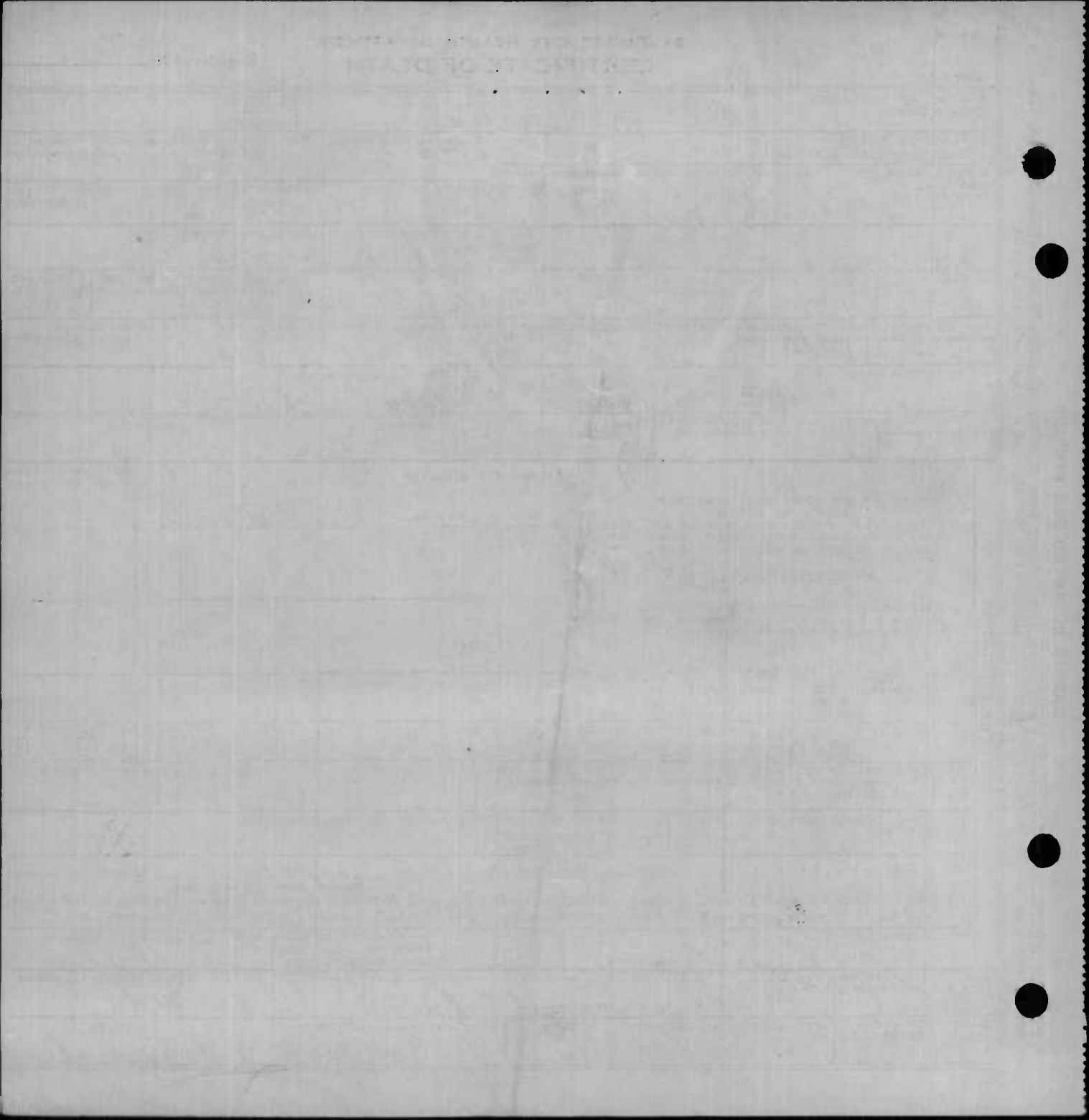
ADDRESS

Wm Cook Inc 1217 St. Paul St.

MARGIN CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.

RENTING IN OF DEATH



H252

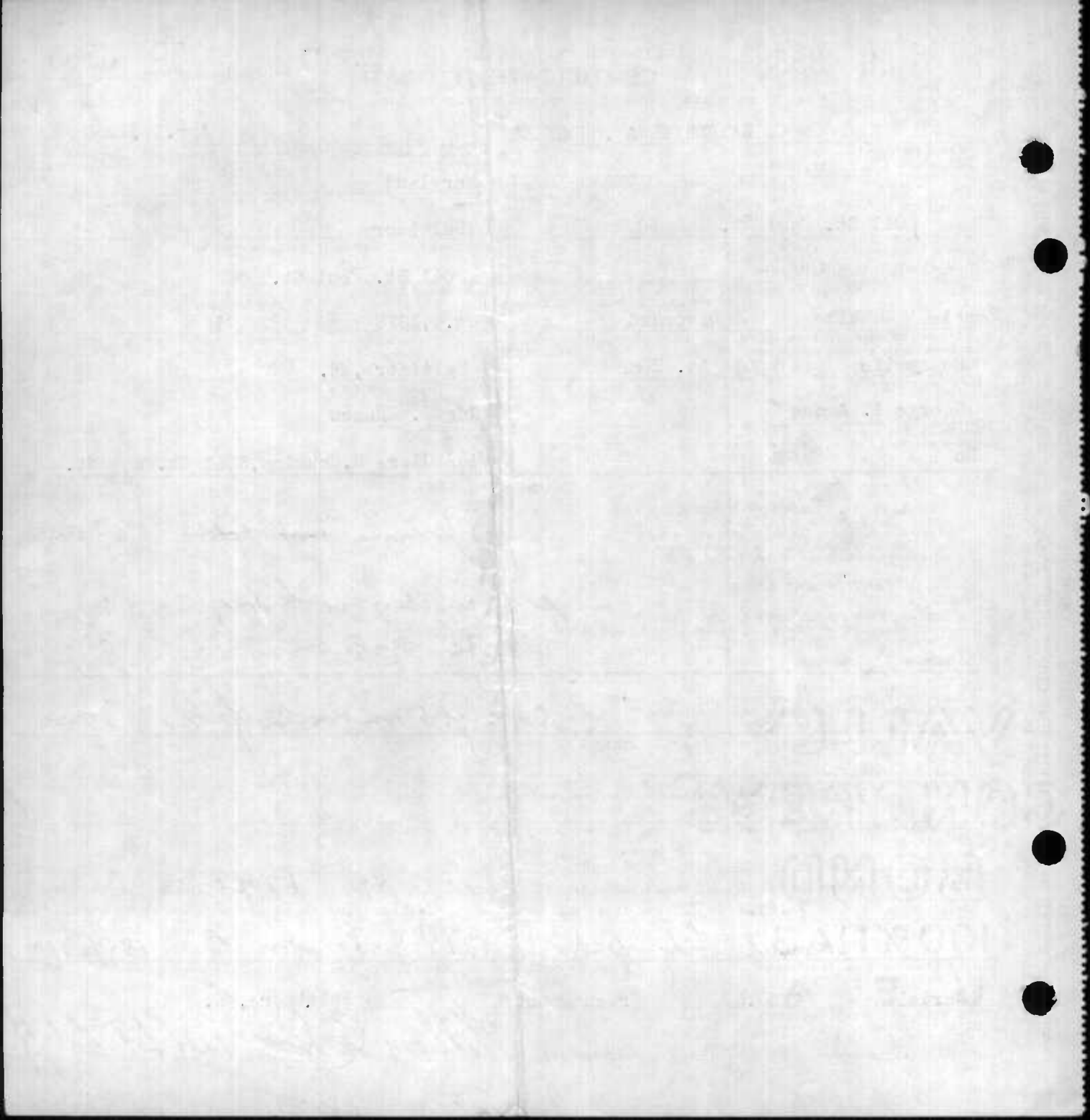
50 3588

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3588

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		KATHERINE A. HOSKINS		Apr. 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
B. FULL NAME OF HOSPITAL OR INSTITUTION 3041 St. Paul St.		A. STATE Maryland			
C. Length of stay in Baltimore Yrs. Mos. Days		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-02			
5. SEX Female		6. COLOR OR RACE White		D. STREET ADDRESS (If rural, give location) 3041 St. Paul St.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH Oct. 9, 1878		9. AGE (In years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At. Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME George A. Amoss		14. MOTHER'S MAIDEN NAME Ida V. Hanson		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Clare B. Hoskins, 3041 St. Paul St.	
18. 446X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. left & right ventricular failure		CAUSE OF DEATH (A) <u>Uremia and left</u> DUE TO (B) <u>arteriosclerotic kidney</u> DUE TO (C) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u> <u>?</u> <u>7 mos</u>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 5, 1949, to 17 Apr, 1950, that I last saw the deceased alive on 16 Apr, 1950, and that death occurred at 8:10A m., from the causes and on the date stated above.					
23A. SIGNATURE Samuel Schenfeld M.D.		23B. ADDRESS 718 E. Preston St.		23C. DATE SIGNED 18 April 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/20/50		24C. NAME OF CEMETERY OR CREMATORY Green Mount	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR APR 18 1950		24F. REGISTRAR'S SIGNATURE William C. Williams	
24G. VS 150		24H. FUNERAL DIRECTOR William C. Williams		24I. ADDRESS 1219 E. Paul St.	

131a





5552

50 3589

BALTIMORE CITY HEALTH DEPARTMENT

50 3589

## CERTIFICATE OF DEATH

Registered No.

534700

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY SZYMANKIEWICZ

2. DATE  
OF  
DEATH

APR 17 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Md.

D. STREET ADDRESS (If rural, give location)

Baltimore, 25-36  
3448 Childs Court

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Acute undifferentiated case leukemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Thrombocytopenia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 4-15-1950 to 4-17-1950, that I last saw the  
deceased alive on 4-17-1950, and that death occurred at 1:25 P.M., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

Doctor L. Quinn

M. O.

JOHN HOPKINS HOSPITAL

4/17/50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

B

4-19-50

Holy Cross

Bach.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

William Williams, M.D.

James H. Keener

130 E. Fairview

74a

CERTIFICATE OF DEATH

MAY 27 1944

NAME

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE

DATE

PLACE

S-350

SUTTON Cu 1185

50 3590

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3590

Registered No.

BIRTH NO. 49-26354

1. NAME OF DECEASED  
(Type or Print)

Carol Sutton

2. DATE  
OF  
DEATH

April 16/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

TANEY

D. STREET ADDRESS (If rural, give location)

519-7 TANEY AVE.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11-30-49

9. AGE (In years  
last birthday)

4

Months: Days

4 16

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bach.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Norman L.

14. MOTHER'S MAIDEN NAME

Kelay C. Calloway

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic Bronchitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C) Prematurity

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-30, 1949 to 4-16, 1950, that I last saw the deceased alive on 4-16, 1950, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

G. C. Robinson

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

B3

24B. DATE

4-18-50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county) (State)

Glen Haven

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter J. Williams, M.D.

25. FUNERAL DIRECTOR

James L. DeLoach

ADDRESS

130 S. Fort Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

519 lanes DE 6456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3591  
Registered No. 50 3591

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Samuel T. Edel Sr.

2. DATE  
OF  
DEATH

4/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md. 1605 Northwick Rd.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. City Md. 27-09

1605 Northwick Rd.

D. STREET ADDRESS (If rural, give location)

1605 Northwick Rd.

c. Length of stay in Baltimore

11 1/2

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

2/9/1900

9. AGE (In years  
last birthday)

50

10. Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervising Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Chevrolet Co.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry T. Edel

14. MOTHER'S MAIDEN NAME

Mary L. Neal

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

213-10-4508

17. INFORMANT

Mr. Samuel T. Edel Jr

ADDRESS

1605 Northwick

18. 442x I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Cardio-vascular-renal  
disease.

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(C) .....  
DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 22, 1949 to 4-16, 1950, that I last saw the deceased alive on 4-16, 1950, and that death occurred at 9:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE

O. L. Ewald Jr.

M. D.

23B. ADDRESS

36 York Court

23C. DATE SIGNED

4-17-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/19/50

24C. NAME OF CEMETERY OR CREMATORY

London Park Cem.

24D. LOCATION (City, town, or county)

Balto. City

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams, Jr.

25. FUNERAL DIRECTOR

Lassahn Funeral Home

ADDRESS

7401 Belair Rd



3926 Nut Ave

8, E 39<sup>th</sup> St.  
Dr. Ewald



# STEEGER

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

Registered No. 50 3592

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs Elizabeth Steeger

2. DATE  
OF  
DEATH

4-17-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 12-02

D. STREET ADDRESS (If rural, give location)

3049 Abell Ave.

c. Length of stay in Baltimore

5. SEX

F.

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 19, 1874

9. AGE (In years  
last birthday)

75

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Clerk (rtd)

10B. KIND OF BUSINESS OR  
INDUSTRY

Bakery

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Adolph Steeger

14. MOTHER'S MAIDEN NAME

Elizabeth Kroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. F. Joseph Huppman, 425 Murdock Rd.

18. 578 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) GENERALIZED PERITONITIS  
DUE TO DUE TO PERFORATION  
SIGMOID & CECUM

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) GENERALIZED ARTERIO-SCLEROSIS  
DUE TO  
(C) CACHEXIA

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/5/1950 to 4/17/1950, that I last saw the  
deceased alive on 4/17/1950, and that death occurred at 5:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

4/20/50

Loudon Park Cem.

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

Wm. J. Isenauer

Wm. J. Isenauer &amp; Sons Balto Md.

11-11-1912

Mr. E. J. [illegible]

St. James Hospital

Nov. 11, 1912

White

Married

Married

Hobbs

11-11-1912

Nov. 11, 1912

Married

50 3593

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3593

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William E. Busch

2. DATE  
OF  
DEATH

4/16/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

West Baltimore Gen'l Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

Pinehurst

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2-12-1892

9. AGE (In years,  
last birthday)

58

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Slater + Tiler (roof)

10B. KIND OF BUSINESS OR  
INDUSTRY

Self employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William E. Busch, Sr.

14. MOTHER'S MAIDEN NAME

Gertrude Niedhammer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War #1

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Md.

Mrs. Susie G. Busch

Pinehurst, Pasadena

18.

4/20/50

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Myocardial Infarction

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Atherosclerotic cardiovascular  
disease, with anginal symptoms.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK☐NOT WHILE  
AT WORK☐22. I hereby certify that I attended the deceased from 3/31/50, 19, to 4/16, 1950, that I last saw the  
deceased alive on 4/16, 1950, and that death occurred at 3:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Sara E. Bennett

M. D.

23B. ADDRESS

West Baltimore Gen'l Hosp

23C. DATE SIGNED

4/16/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/20/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Richner &amp; Sons Balto Md.

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3594**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Cecilia Feldman*2. DATE  
OF  
DEATH*April 16, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
*Md.*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*203 N. Belnord Ave.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*203 N. Belnord Ave.*

c. Length of stay in Baltimore

5. SEX

*F*

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*widow*

8. DATE OF BIRTH

*Aug. 8, 1881*9. AGE (In years  
last birthday)*68*10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Seamstress*

10B. KIND OF BUSINESS OR INDUSTRY

*Pajama Mfgs.*

11. BIRTHPLACE (State or foreign country)

*Md.*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Henry Homberg*

14. MOTHER'S MAIDEN NAME

*Anna Oberlein*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.*212-10-6504*

17. INFORMANT

ADDRESS

*Av.**Mr. Gilbert O. Feldman 203 N. Belnord*18. *420.1*DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) *Coronary Occlusion*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Hypertensive Cardiovascular Disease*

DUE TO

(C) *Carcinoma of uterus*INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspector* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*William G. Helbert*23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

*4/16/50*24A. BURIAL, CREMA  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*4/19/50*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Olivet Cem.*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William G. Helbert*

25. FUNERAL DIRECTOR

*Wm. J. Dickner & Sons - Balt*

ADDRESS

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1901.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 1, 1899, CONCERNING THE LANDS BELONGING TO THE STATE

AND THE PROCEEDINGS THEREON

FOR THE YEAR 1900

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

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1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.

ALBANY: J. B. LIPPINCOTT & CO., PRINTERS.

1901.



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3595  
Registered No. 2698

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Emma Staples*

2. DATE  
OF  
DEATH

*April 16, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Md.*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*1118 N. Fulton Ave.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 16-04*

D. STREET ADDRESS (If rural, give location)

*1118 N. Fulton Ave.*

c. Length of stay in Baltimore

*4 mos.*

5. SEX

*F*

6. COLOR OR RACE

*Col*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

B. DATE OF BIRTH

*Feb. 3, 1875*

9. AGE (In years last birthday)

*75*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Domestic*

10B. KIND OF BUSINESS OR INDUSTRY

*Domestic*

11. BIRTHPLACE (State or foreign country)

*Mechanic Va.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.*

13. FATHER'S NAME

*Henry W. Staples*

14. MOTHER'S MAIDEN NAME

*Jane W. Staples*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

*1-1-1-1-1-1-1-1-1-1*

17. INFORMANT

*A.C. Staples & 1224 N. Fulton*

ADDRESS

18.

*331X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebral hemorrhage*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*6 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertension & atherosclerosis*

DUE TO

*Unknown*

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *4-1-1950* to *4-16-1950* that I last saw the deceased alive on *4-15-1950* and that death occurred at *6:50 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*James A. Saunders*

M. D.

23B. ADDRESS

*1624 N. Stricker St.*

23C. DATE SIGNED

*4-17-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Removal*

24B. DATE

*April 8/50*

24C. NAME OF CEMETERY OR CREMATORY

*Mechanic Va.*

24D. LOCATION (City, town, or county)

*Mechanic Va.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*APR 18 1950*

REGISTRAR'S SIGNATURE

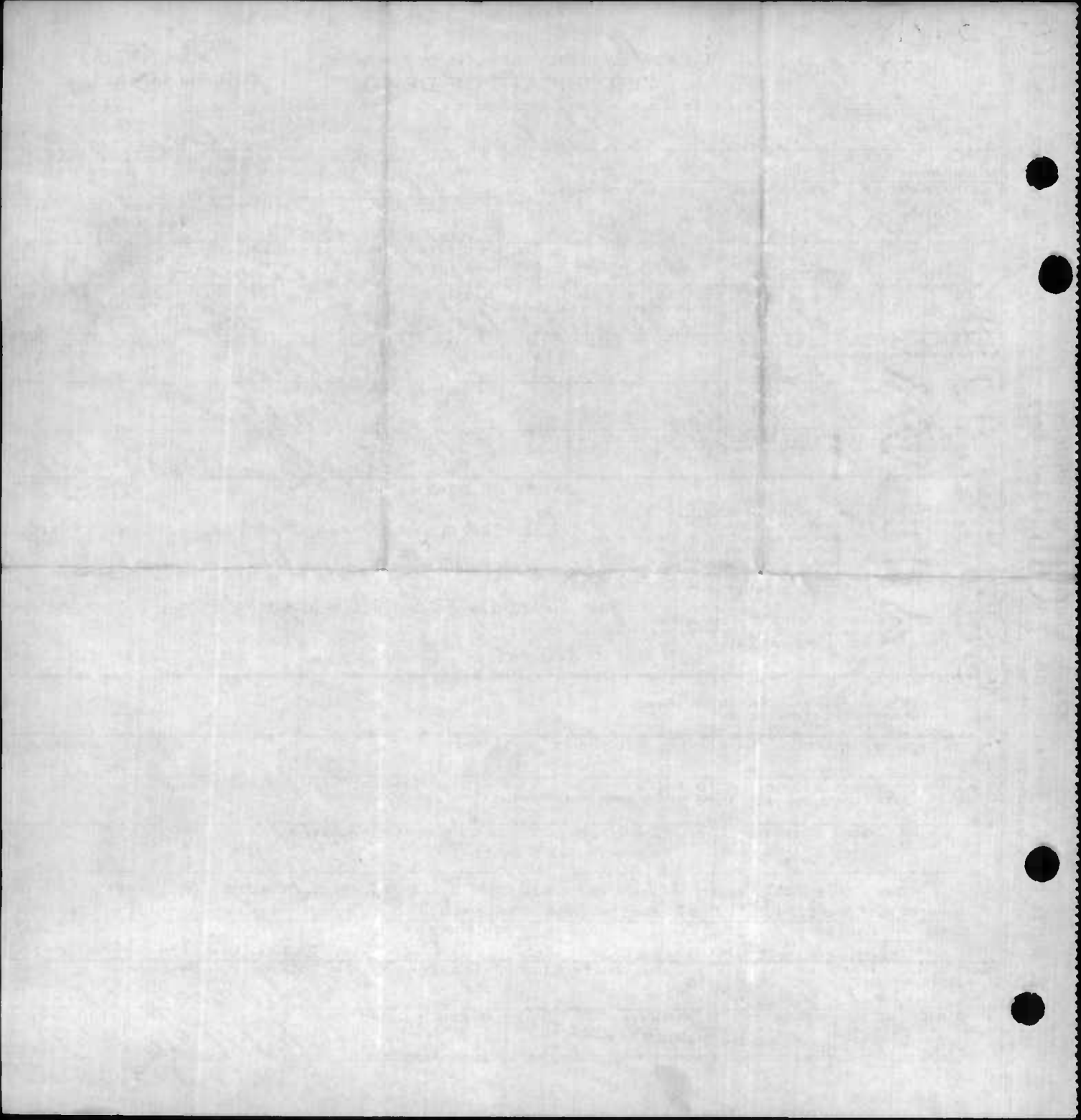
*William W. Williams, M.D.*

25. FUNERAL DIRECTOR

*James A. Saunders*

ADDRESS

*83a 1124 N. Caroline*



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3596**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**Mrs. Susie Julia Goodman**2. DATE  
OF  
DEATH**April 17, 1950**

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE **Maryland** B. COUNTY (before admission)b. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION**3646 Elm Avenue**c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
**Baltimore**

d. STREET ADDRESS (If rural, give location)

**3646 Elm Avenue**

c. Length of stay in Baltimore

**47 years**Yrs.  
Mos.  
Days

5. SEX

**Female**

6. COLOR OR RACE

**White**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**Widow**

8. DATE OF BIRTH

**December 15, 1869**9. AGE (In years  
last birthday)**80**If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**At Home**10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Virginia**12. CITIZEN OF  
WHAT COUNTRY?**U S A**

13. FATHER'S NAME

**Thomas P. Wappett**

14. MOTHER'S MAIDEN NAME

**Nancy Rider**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL  
SECURITY NO.**219-01-6990**

17. INFORMANT

**Mrs. Ruth Sprague**

ADDRESS

**821 Union Avenue**

18.

**420.1**

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) **Coronary occlusion**

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH**15 mins.**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) **Atherosclerosis**

DUE TO

**and Hypertension****undef.****undef.**

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March** 19**49**, to **17 April**, 19**50**, that I last saw the  
deceased alive on **5 Oct**, 19**49**, and that death occurred at **8 A** m., from the causes and on the date stated above.

23a. SIGNATURE

**Sheila B. Brown**

M. D.

23b. ADDRESS

**2020 N. Charles St**

23c. DATE SIGNED

**17 April 1950**24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)**Burial**

24b. DATE

**April 20, 1950**

24c. NAME OF CEMETERY OR CREMATORY

**Woodlawn**

24d. LOCATION (City, town, or county)

**Baltimore Co., Maryland**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR**APR 18 1950**

REGISTRAR'S SIGNATURE

**William J. Williams, M.D.**

25. FUNERAL DIRECTOR

**Burgee Funeral Home**

ADDRESS

**3631 Falls Road**

CERTIFICATE OF DATA

April 17, 1950

Mr. J. H. [unclear]

Ward

25 [unclear]

300 [unclear]

300 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

100 [unclear]

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3597

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Newton Rigney

2. DATE  
OF  
DEATH

April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3339 Chestnut Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3339 Chestnut Avenue

c. Length of stay in Baltimore

56 years

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

July 8, 1866

9. AGE (In years  
last birthday)

83

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Stationery Fireman

10B. KIND OF BUSINESS OR  
INDUSTRY

Retired 10 years

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U S A

13. FATHER'S NAME

John Rigney

14. MOTHER'S MAIDEN NAME

Mary Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-10-3450

17. INFORMANT

Miss Mildred Rigney

ADDRESS

3339 Chestnut Avenue

18. 442X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cardio-renal-vascular Disease

8 yrs

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1949 to April 15, 1950, that I last saw the  
deceased alive on April 15, 1950, and that death occurred at 7:45 A.m., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Wilson

M. D.

23B. ADDRESS

617 W. 40th St.

23C. DATE SIGNED

4/15/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 18, 1950

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Baltimore Co., Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Burgee Funeral Home

ADDRESS

3631 Falls Road

# CERTIFICATE OF DEATH

1900

1900

1900

1900

1900

1900

1900

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1900

1900



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3598  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Raymond

Otho

2. DATE  
OF  
DEATH

April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Maryland

B. COUNTY before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1406 Carroll St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 10, 1899

9. AGE (In years  
last birthday)

50

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

City

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

Frank Stanley

14. MOTHER'S MAIDEN NAME

Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

215-05-1381

17. INFORMANT

ADDRESS

Mrs. Emma Taylor 1013 S. Fremont

18. E 8 16 - 1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial rupture

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Bayard st. &amp; Washington Blvd. 21/2

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

April 15, 1950 7:02 P. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into fire engine

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

April 17, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-19-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem

24D. LOCATION (City, town, or county)

A. A. Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

W. Biddle

(Mrs) Frances A. Hemsley

VS 151

N-861.0

98898

(Mrs) Frances A. Hemsley

170C

STATE OF ALABAMA  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH



CASTERLOW

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3599 Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Casterlow

2. DATE  
OF  
DEATH

April 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Hartford

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Joppatowne

6200

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3-8-96

9. AGE (In years  
last birthday)

54

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Edgewood Proving

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

James Casterlow

14. MOTHER'S MAIDEN NAME

Rose Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHN HOPKINS HOSPITAL

18.

592X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Anemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Chronic glomerulonephritis ? 10 yrs

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 4-10, 1950, to 4-16, 1950 that I last saw the  
deceased alive on 4-16, 1950, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

David E. Rogers, M.D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-20-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Zion Cem

24D. LOCATION (City, town, or county) (State)

Longgreen, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Frances A. Hemmley, 578 W. Biddle

STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

 Registered No. **50 3600**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*MINNIE ATRICE EARY*2. DATE  
OF  
DEATH*4-16-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)*44 UNION MEMORIAL HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*BALTIMORE**13-08*

D. STREET ADDRESS (If rural, give location)

*1329 W 37TH ST*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*FEMALE*

6. COLOR OR RACE

*WHITE*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*WIDOWED*

8. DATE OF BIRTH

*3-8-1872*9. AGE (In years  
last birthday)*58*10. Under 1 Year  
Months: Days*1 7*11. Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*HOUSEWIFE*10b. KIND OF BUSINESS OR  
INDUSTRY*NONE*

11. BIRTHPLACE (State or foreign country)

*STRASBURG VIRGINIA*12. CITIZEN OF  
WHAT COUNTRY?*USA*

13. FATHER'S NAME

*JOHN GRUBBS*

14. MOTHER'S MAIDEN NAME

*?*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*NO*16. SOCIAL  
SECURITY NO.

17. INFORMANT

(SON) ADDRESS

*RAYMOND FISCHER**1329 W 37TH ST  
BALT.*18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Myocardial infarction*

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

*Coronary atherosclerosis*

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

*Ischemic heart disease*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-11*, 1950, to *4-16*, 1950, that I last saw the  
deceased alive on *4-16*, 1950, and that death occurred at *10 A.m.*, from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*APR 18 1950**Registrar's Signature**Justin E. Donovan 3818 Roland Ave*







UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

100-100000



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3602  
Registered No. 50 3602

B-620  
50 3602  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELLEN V. BROOKS</b>			2. DATE OF DEATH <b>April 16, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>West Baltimore General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2102 Bryant Avenue</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>1936 -</b>	9. AGE (In years last birthday) <b>13</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>ROBERT B. BROOKS</b>			14. MOTHER'S MAIDEN NAME <b>NINA E. DIERKSE</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT ADDRESS <b>MR. ROBT. B. BROOKS - 2102 BRYANT AVE</b>		

18. <b>E 921.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Asphyxia due to accidental aspiration of vomitus</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>2102 Bryant Avenue</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 16, 1950 1.30pm.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>apparently aspirated vomitus due to excitement</b>	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R S Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.		23C. DATE SIGNED <b>April 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-19-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEM.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 18 1950</b>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR <b>WIEDEFELD &amp; SON</b>	
VS 151				ADDRESS <b>GREENMOUNT AVE Y 22ND ST</b>	

N 933.0

RECEIVED FOR DEPOSIT  
CORPORATE DEPOSIT

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3603

BIRTH NO. 50-03706

1. NAME OF DECEASED  
(Type or Print)

BABY LOUIS MACK (Hooper)

2. DATE  
OF  
DEATH

4-14-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD

B. COUNTY

BALT

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 Univ. Hoop.

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Balt.

D. STREET ADDRESS (If rural, give location)

Green v. 701 PIERCE ST.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Bl.

7. SINGLE MARRIED.  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 21, 1950 6 Wks.

9. AGE (In years last birthday)

10 Under 1 Year

Months

Days

11 Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Louis Smach

14. MOTHER'S MAIDEN NAME

Helen Grove

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Father

ADDRESS

701 Pierce St.

18. 772.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute - Aspiration of Vomitus

2 wks

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Difficult feeding problem

over

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 3, 1950, to April 14, 1950, that I last saw the deceased alive on April 14, 1950, and that death occurred at 3:00 P.m., from the causes and on the date stated above.

23A. SIGNATURE

W. Bonmann M.D.

23B. ADDRESS

Univ. Hoop.

23C. DATE SIGNED

4-16-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

April 19

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

A. Halstead 918 1/2 N. 161c

APR 18 1950

S 150

N-933.0

What was the underlying cause?  
Was death due to pneumonia?

Letter in document file 50-3603 - 5/4/50.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3604

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Jones

2. DATE  
OF  
DEATH

4/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

University Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Frederick A. A. Co., Md 5200

D. STREET ADDRESS (If rural, give location)

R 7 D Glenburnie

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1918

9. AGE (In years last birthday)

71

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S M maiden NAME

Annie Stonnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Rev James Jones A. A. Co. Md

18. 4700

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Myocardial failure

DUE TO

Myocardial infarction, acute

## ANTECEDENT CAUSES

(B)

DUE TO

Hypertensive + arteriosclerotic

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

heart disease

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/19, 1950, to 4/15, 1950, that I last saw the deceased alive on 4/15, 1950, and that death occurred at 1:15 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

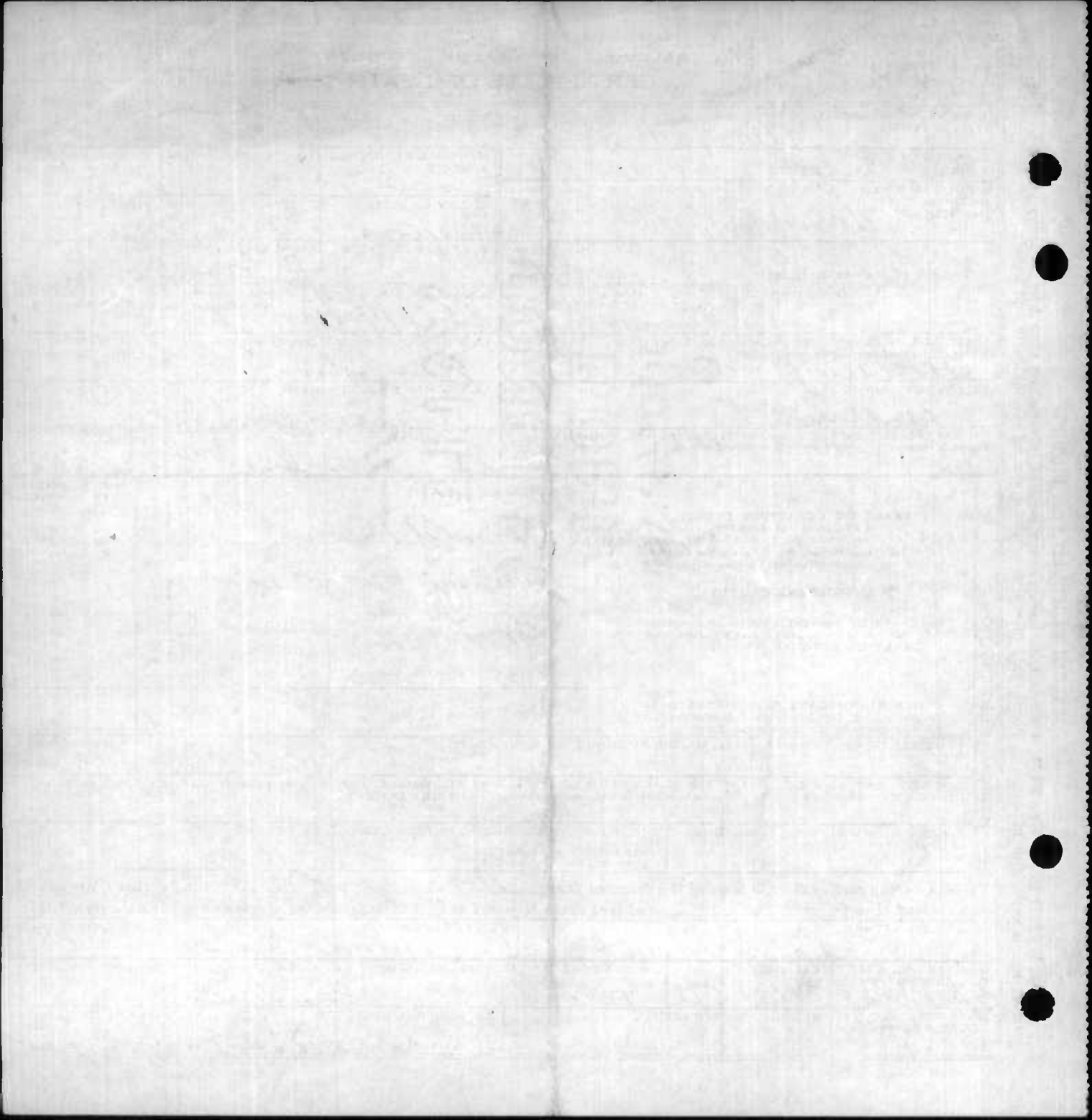
(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3605**BIRTH NO. **50 3605**

1. NAME OF DECEASED (Type or Print) <b>VIOLA WILSON</b>		2. DATE OF DEATH <b>April 16, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>516 McMechin Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>8-30-1902</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	9. AGE (In years last birthday) <b>47</b>
13. FATHER'S NAME <b>William Wilson</b>		11. BIRTHPLACE (State or foreign country) <b>Danville, Virginia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Lydian Mason</b>	
17. INFORMANT <b>Rosa West - 405 Wilson St.</b>		ADDRESS	

18. **023 X I** CAUSE OF DEATHDISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Luetic aortitis**

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

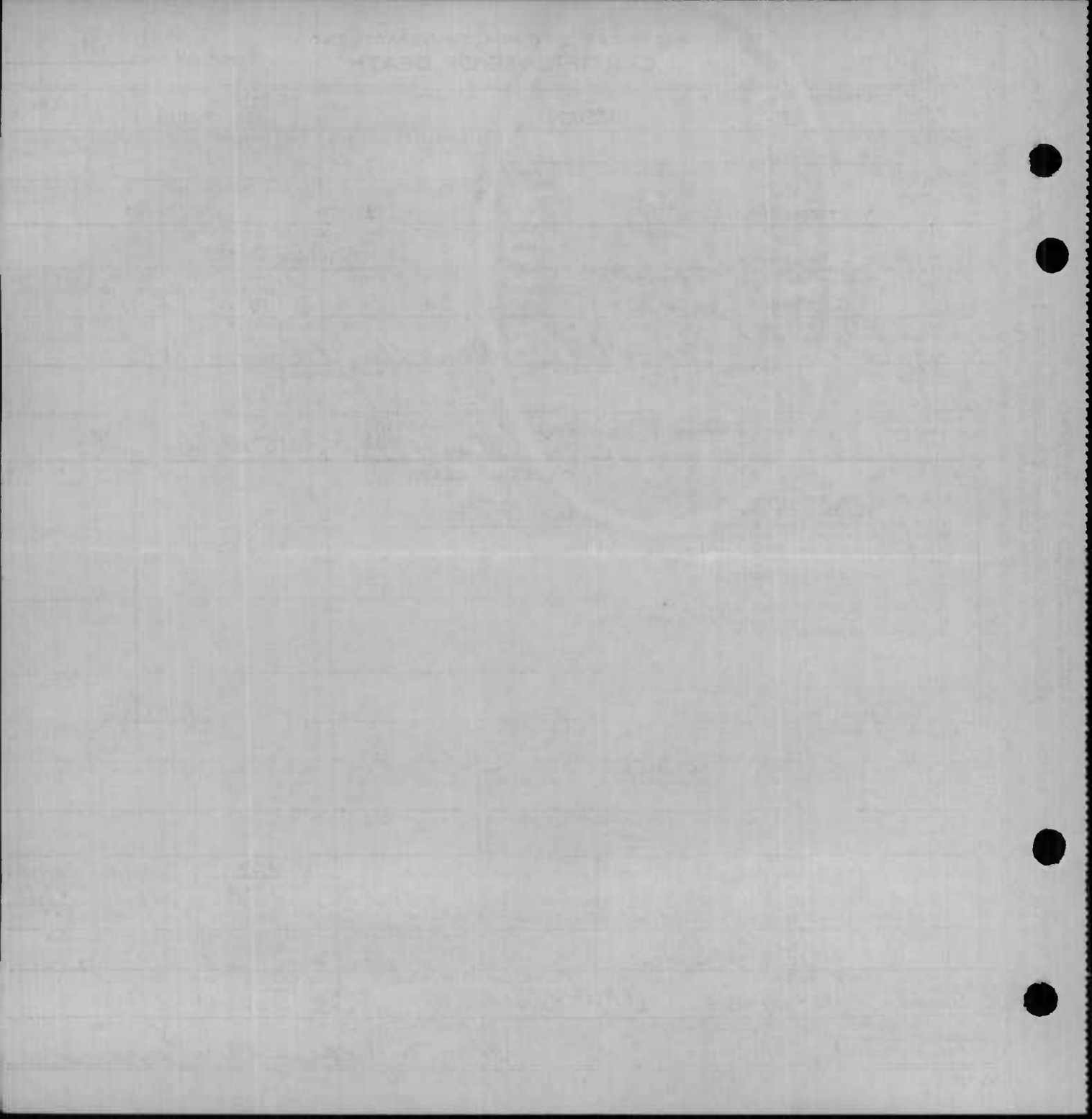
## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. B. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>April 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-19-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore 17.</b>		25. FUNERAL DIRECTOR <b>2401 N. A. Jackson - 916 Penna. Ave.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 18 1950</b>		REGISTRAR'S SIGNATURE <b>William Wilson</b>		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

460 CERTIFICATE CORRECTED				BALTIMORE CITY HEALTH DEPARTMENT		50 3606	
BIRTH NO. 50 3606				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Edward Taylor</b>				2. DATE OF DEATH <b>April (16) 1950</b>			
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 17-02</b>			
c. Length of stay in Baltimore Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <b>577 W. Hoffman St.</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>7-17-1904</b>	9. AGE (In years last birthday) <b>35</b>	If Under 1 Year Months: Days	If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Farm Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Spottsylvania Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Cora Elsie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Taylor - 577 W. Hoffman St.</b>		ADDRESS	
18. <b>E 983 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fracture of skull &amp; epidural hemorrhage</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO			
				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Stable</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>803 Vincent St.</b>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>April 13, 1950 5:30 P.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Blunt force</b>			
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE <b>Carl L. Royer</b>				23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>April 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-19-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>A. A. Co. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 18 1950</b>		REGISTRAR'S SIGNATURE <b>Thomas A. Jackson</b>		25. FUNERAL DIRECTOR <b>Thomas A. Jackson - 916 Penn. Ave.</b>		ADDRESS	
VS 151		N- 803.0		888VV		168 ✓	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial		18. Signature of Interment	
19. Signature of Burial		20. Signature of Interment		21. Signature of Burial	
22. Signature of Interment		23. Signature of Burial		24. Signature of Interment	
25. Signature of Burial		26. Signature of Interment		27. Signature of Burial	
28. Signature of Interment		29. Signature of Burial		30. Signature of Interment	
31. Signature of Burial		32. Signature of Interment		33. Signature of Burial	
34. Signature of Interment		35. Signature of Burial		36. Signature of Interment	
37. Signature of Burial		38. Signature of Interment		39. Signature of Burial	
40. Signature of Interment		41. Signature of Burial		42. Signature of Interment	
43. Signature of Burial		44. Signature of Interment		45. Signature of Burial	
46. Signature of Interment		47. Signature of Burial		48. Signature of Interment	
49. Signature of Burial		50. Signature of Interment		51. Signature of Burial	
52. Signature of Interment		53. Signature of Burial		54. Signature of Interment	
55. Signature of Burial		56. Signature of Interment		57. Signature of Burial	
58. Signature of Interment		59. Signature of Burial		60. Signature of Interment	
61. Signature of Burial		62. Signature of Interment		63. Signature of Burial	
64. Signature of Interment		65. Signature of Burial		66. Signature of Interment	
67. Signature of Burial		68. Signature of Interment		69. Signature of Burial	
70. Signature of Interment		71. Signature of Burial		72. Signature of Interment	
73. Signature of Burial		74. Signature of Interment		75. Signature of Burial	
76. Signature of Interment		77. Signature of Burial		78. Signature of Interment	
79. Signature of Burial		80. Signature of Interment		81. Signature of Burial	
82. Signature of Interment		83. Signature of Burial		84. Signature of Interment	
85. Signature of Burial		86. Signature of Interment		87. Signature of Burial	
88. Signature of Interment		89. Signature of Burial		90. Signature of Interment	
91. Signature of Burial		92. Signature of Interment		93. Signature of Burial	
94. Signature of Interment		95. Signature of Burial		96. Signature of Interment	
97. Signature of Burial		98. Signature of Interment		99. Signature of Burial	
100. Signature of Interment		101. Signature of Burial		102. Signature of Interment	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3607

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNE MARIE SONNER

2. DATE  
OF  
DEATH

Apr. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

US Marine Hospital

Wyman Pk. Drive &amp; 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Co.

D. STREET ADDRESS (If rural, give location)

19 Blister Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/22/12

9. AGE (In years last birthday)

37

If Under 1 Year Months Days  
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NY

12. CITIZEN OF USA OR FOREIGN COUNTRY?

USA

13. FATHER'S NAME

William Peer

14. MOTHER'S MAIDEN NAME

Irene (Martin) GILMARTIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT ADDRESS

Records- US Marine Hospital, Balto, Md.

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hodgkin's disease  
with abdominal node metastases

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

7 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Jaundice, etiology unknown

DUE TO

Unknown

(C) Ulcers of stomach and small intestine

Unknown

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(D) Ovarian cysts, bilateral

Unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 3, 1950, to Apr. 16, 1950, that I last saw the deceased alive on Apr. 16, 1950, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

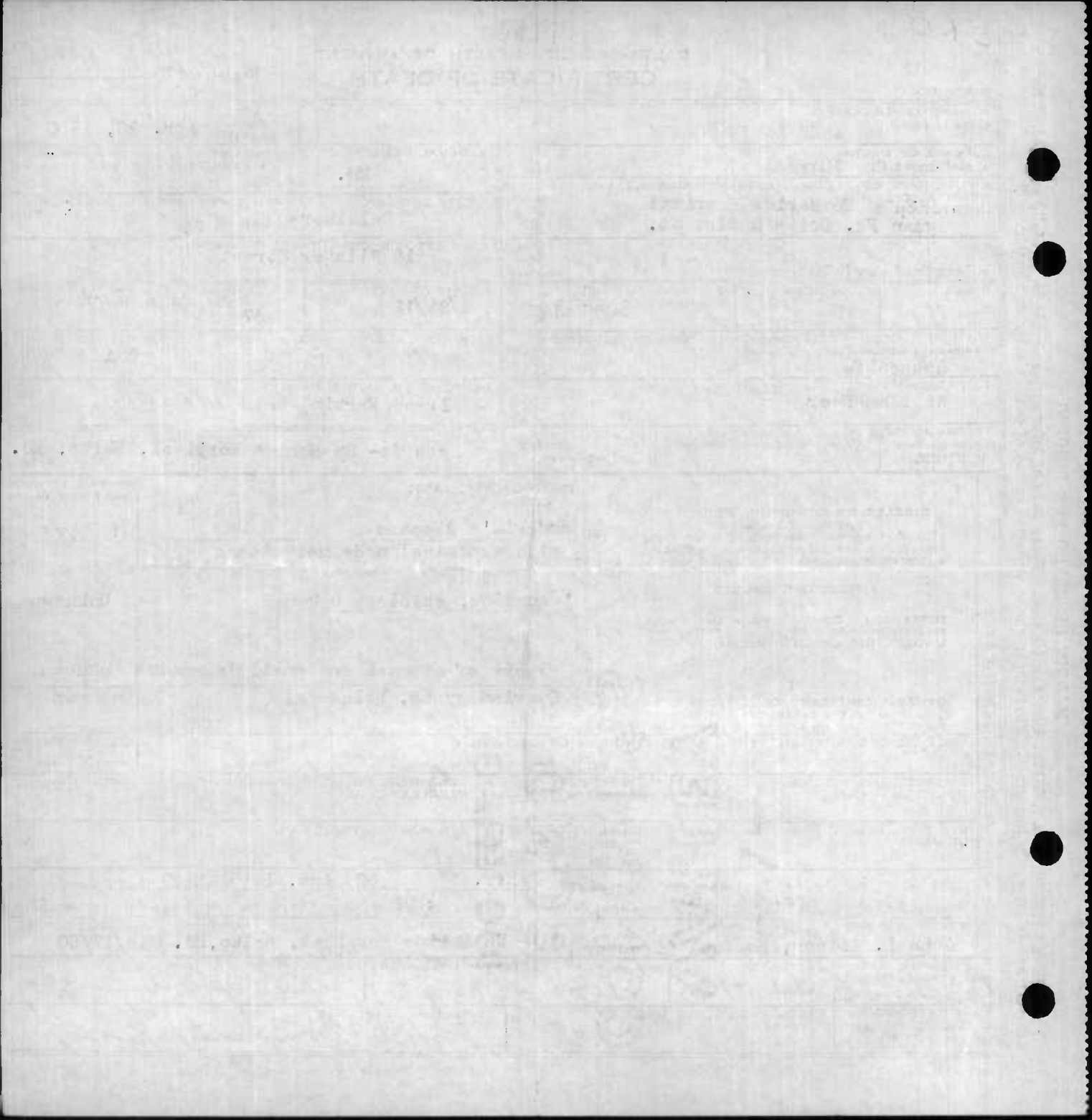
25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

John L. Wilson, M.D.

John E. Connelly, Esq.



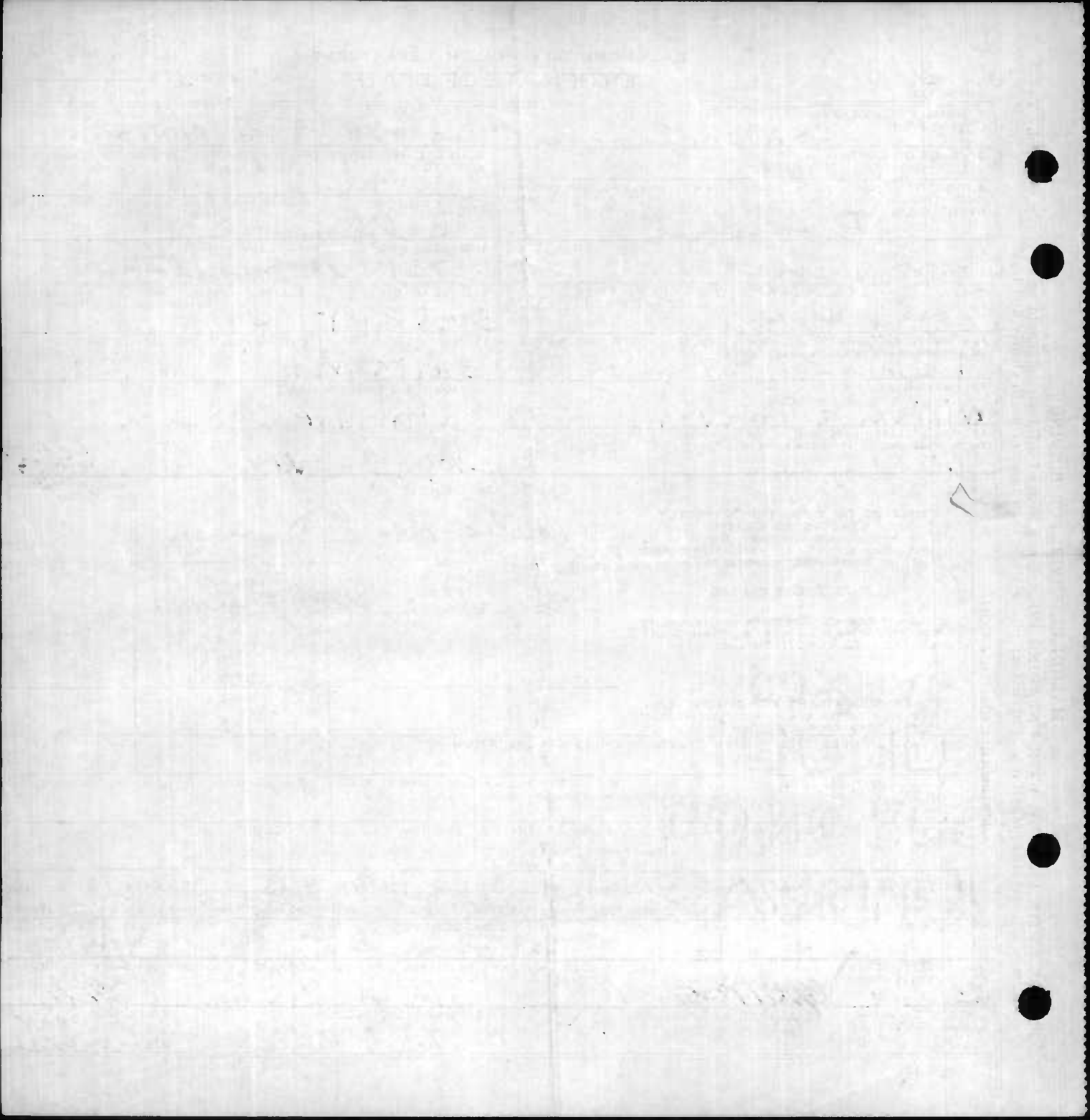
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**CRAVEN**  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3608

Registered No. \_\_\_\_\_

BIRTH NO. <b>50 3608</b>		1. NAME OF DECEASED (Type or Print) <b>CRAVEN, Thomas Wesley</b>		2. DATE OF DEATH <b>4/14/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 4-02</b>			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>731 W. Saratoga</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE/MARRIED/WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Sept. 14, 1910</b>	9. AGE (In years last birthday) <b>39</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Flooding Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
13. FATHER'S NAME <b>William H. Craven</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Johnson</b> ✓			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Lloyd Craven W. Saratoga 731 St.</b>	
18. <b>023X</b>		CAUSE OF DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Ischemic Heart Disease</b>			
ANTECEDENT CAUSES		(B) <b>Coronary Heart Failure</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/29</b> , 19 <b>50</b> to <b>4/13</b> , 19 <b>50</b> that I last saw the deceased alive on <b>4/13</b> , 19 <b>50</b> , and that death occurred at <b>8</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>John H. Holmes</b>		23B. ADDRESS <b>Provident</b>		23C. DATE SIGNED <b>4/14/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>April 18-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Catholic Memorial Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Md.</b>		25. FUNERAL DIRECTOR <b>Mrs. Kate B. Williams</b>		ADDRESS <b>322 N. Schuman St.</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3609

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Jolan Medgyesi A-77293

2. DATE  
OF  
DEATH

APR 18 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Calif.

V-04

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Los Angeles

D. STREET ADDRESS (If rural, give location)

508 1/2 S. Westlake

c. Length of stay in Baltimore

12

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMATION ADDRESS

18.

754.6  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Congenital Cyanotic Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

Life

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Pure pulmonary stenosis

"

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 4-6-1950 to 4-18-1950 that I last saw the  
deceased alive on 4-18-1950, and that death occurred at 5:12 A.M., from the causes and on the date stated above.

23A. SIGNATURE,

23B. ADDRESS

23C. DATE SIGNED

Harrison Clark Spencer

M. D.

JOHNS HOPKINS HOSPITAL

4-18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Cremation

4-18-50

Loudon Park

Evel Ave. Balto.

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

John O. Mitchell

1900 Eutaw Place







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

George C. Wehner

2. DATE  
OF  
DEATH

Apr. 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4801 Morello Road

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4801 Morello Road

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Apr. 9, 1877

9. AGE (in years, last birthday)

73

10. Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Ignatius Wehner

14. MOTHER'S MAIDEN NAME

Marie Fink

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Christina Wehner, 4801 Morello

18.

162X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized metastases

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 year

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan, 1948, to 4-16, 1950, that I last saw the deceased alive on 4-16, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-19-50

24C. NAME OF CEMETERY OR CREMATORY

Oaklawn

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

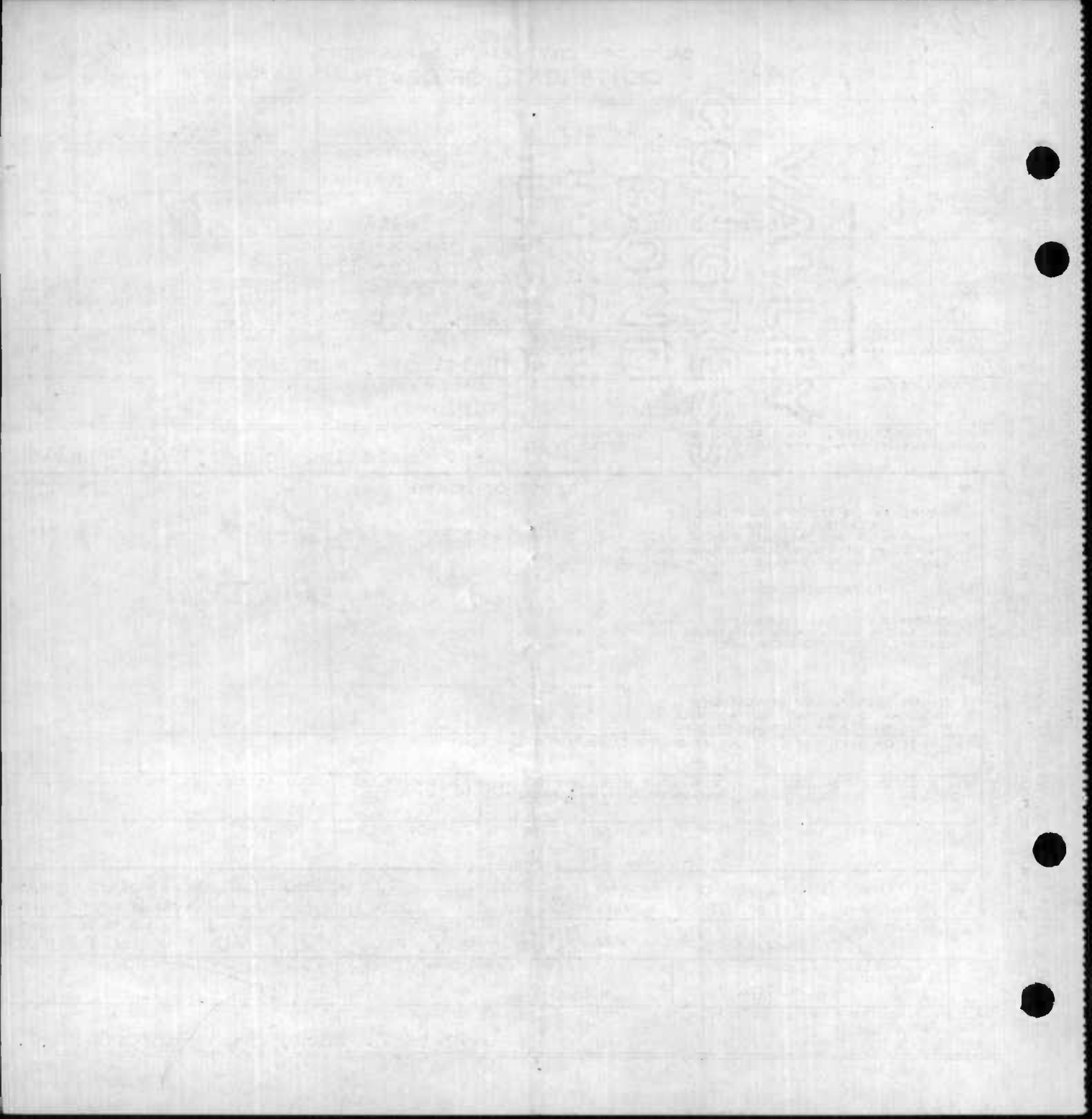
25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

William J. Williams, M.D.

Leonard J. Ruck, 5305 Harford Road.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3611  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**JAMES S. E. HANN**

2. DATE  
OF  
DEATH

**APR. 17-1950**

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

\_\_\_\_\_

5. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

**3100 HAMILTON Ave**

6. CITY OR TOWN (If outside corporate limits, give township)

**BALTIMORE**

7. STREET ADDRESS (If rural, give location)

**3100 HAMILTON Ave.**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

8. SEX

**MALE**

9. COLOR OR RACE

**WHITE**

10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**WIDOWED**

11. DATE OF BIRTH

**MAY 9-1872**

12. AGE (In years, last birthday)

**77**

13. Under 1 Year Months: Days Hours: Min.

14. Under 24 Hours

15. Under 1 Year

16. Under 24 Hours

17. Under 1 Year

18. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**RETIRED**

10B. KIND OF BUSINESS OR INDUSTRY

**PAINTER**

11. BIRTHPLACE (State or foreign country)

**FREDERICK - Md.**

12. CITIZEN OF WHAT COUNTRY?

\_\_\_\_\_

13. FATHER'S NAME

**RUBIN HANN**

14. MOTHER'S MAIDEN NAME

**?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**MRS. HARRY NORRIS - 3100 HAMILTON**

18.

**422.1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Chronic Myocarditis (Infected)**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

**years**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Jan**, 19**47**, to **4/17**, 19**50**, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

**Walter W. Galloway**

23B. ADDRESS

**5703 Hartford Rd**

23C. DATE SIGNED

**4/18/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**BURIAL**

24B. DATE

**4-20-50**

24C. NAME OF CEMETERY OR CREMATORY

**Morland Park**

24D. LOCATION (City, town, or county)

**Baltimore**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**APR 18 1950**

**Walter W. Galloway**

**L. J. Luck**

**5805 Hartford Rd**

Dr. Golley

B-435 Dr. Machen

6331 Belair Road

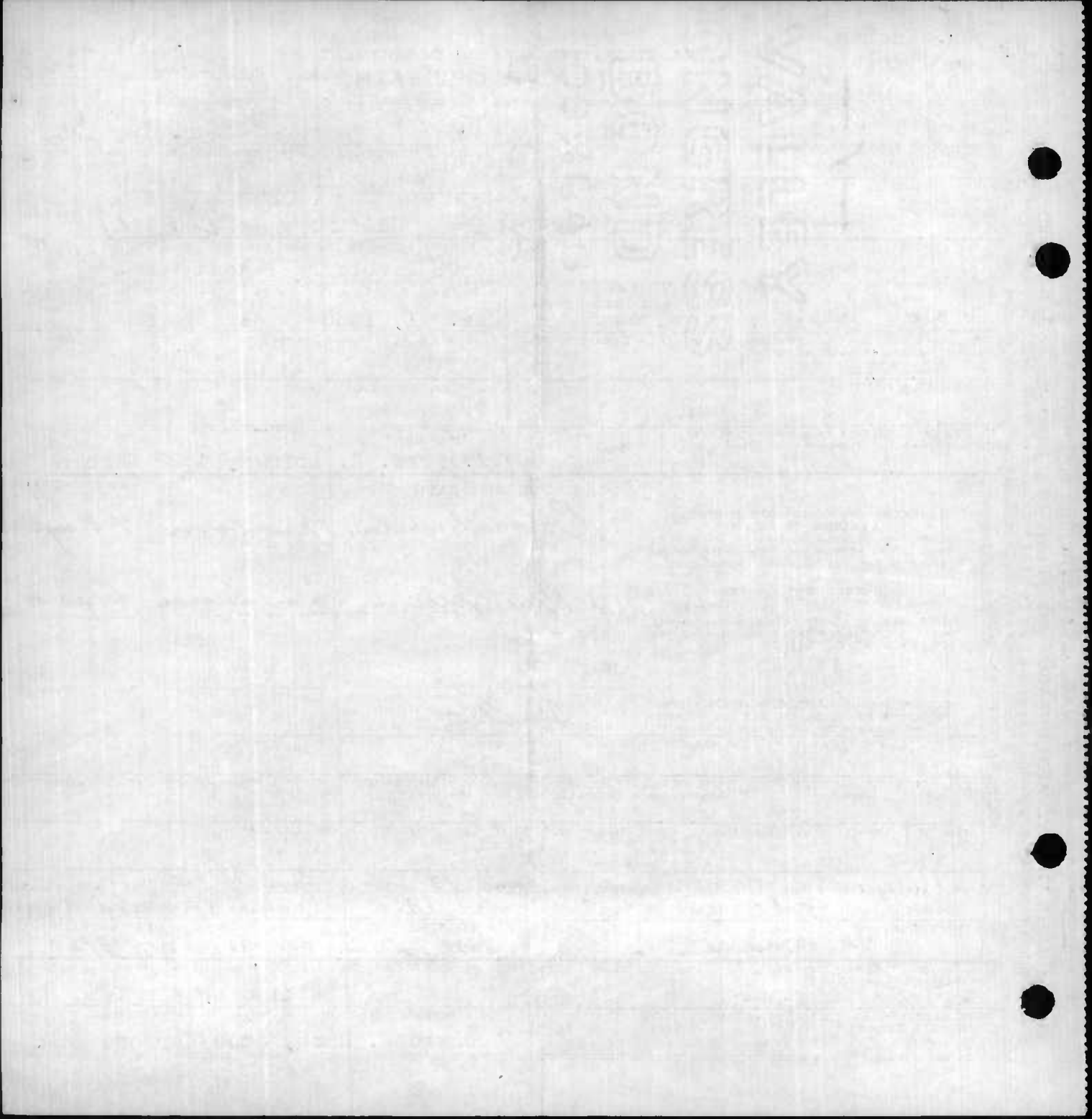
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3612

BIRTH NO. 50 3612

1. NAME OF DECEASED (Type or Print) <b>Laura Brittain</b>			2. DATE OF DEATH <b>Apr. 16, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>4528 Marble Hall Road</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-09</b>		
C. Length of stay in Baltimore Yrs. Mos. Days <b>4528 Marble Hall Road</b>			D. STREET ADDRESS (If rural, give location) <b>4528 Marble Hall Road</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Mar. 11, 1866</b>		9. AGE (in years; last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>? Snyder</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Hall Mr. Fred. S. Hormes, 4528 Marble</b>		

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Artery Thrombosis</b> (A) DUE TO		CAUSE OF DEATH <b>Coronary Artery Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic Heart Disease</b> (B) DUE TO		<b>Arteriosclerotic Heart Disease</b>		<b>5 yrs +</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Senility</b> (C)					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 13, 1950</b> , to <b>April 16, 1950</b> , that I last saw the deceased alive on <b>April 15, 1950</b> , and that death occurred at <b>3A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. W. Machen</b> M. D.		23B. ADDRESS <b>6331 Belair Rd. - 16</b>		23C. DATE SIGNED <b>4/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-19-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, 5305 Harford Road</b>			





F-651

50 3613

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3613  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PHILIP LEONARD FornoFF

2. DATE  
OF  
DEATH

4/17/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

St Josephs Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore Md 27-05

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3120 Orlando Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Nov. 13 - 1893

9. AGE (In years  
last birthday)

56

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

FOREMAN - MACHINIST - Crown Cork - Seal

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Peter FornoFF

14. MOTHER'S MAIDEN NAME

Elizabeth Vogel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-09-8188

17. INFORMANT

Mrs. Grace L. FornoFF - 3120

ADDRESS ORLANDO

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELAT-  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. J. Lubinski

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/20/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

L. J. Luck

5305 Hanford Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

TO BE FILLED OUT BY THE REGISTRAR

IN THE

STATE OF

NEW YORK

IN THE

CITY OF

NEW YORK

IN THE

WARD OF

ST. MARK

IN THE

PARISH OF

ST. MARK

IN THE

WARD OF

ST. MARK

IN THE

PARISH OF

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PARISH OF

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IN THE

WARD OF

ST. MARK

W 50 256  
3614BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3614

BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>Wagner, Joseph.</b>			2. DATE OF DEATH <b>Apr. 12, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hosp</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balt.</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1906 E. Fairmount Ave</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>April 23-1897</b>	9. AGE (In years last birthday) <b>57</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dye Letter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>American Can Co</b>		11. BIRTHPLACE (State or foreign country) <b>Balto</b>	
13. FATHER'S NAME <b>George Wagner</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME		
16. SOCIAL SECURITY NO. <b>2</b>			17. INFORMANT ADDRESS <b>Mrs. Anna Wagner - 1906 E. Fairmount Ave</b>		

18. <b>541.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO	CAUSE OF DEATH (A) <b>Acute Coronary Occlusion</b> (B) <b>Coronary artery sclerosis</b> (C) <b>Peptic Ulcer of Duodenum</b> <b>Diverticulum of Duodenum</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>?</b> <b>?</b> <b>?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>April 12, 1950</b>	19B. MAJOR FINDINGS OF OPERATION <b>peptic Ulcer of Duodenum; Diverticulum of Duodenum</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>HOMICIDE</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 10**, 19**50**, to **April 12**, 19**50**, that I last saw the deceased alive on **April 12**, 19**50**, and that death occurred at **1:30 P** m., from the causes and on the date stated above.

23A. SIGNATURE **Harold Resnault, M.D.** M. D. 23B. ADDRESS **Sinai Hosp Baltimore** 23C. DATE SIGNED **Apr. 12, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-21-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>	24D. LOCATION (City, town, or county) (State) <b>Balto</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 18 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>Selig Ziehl 403 S. Wolfe St</b>	

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

C-640  
50 3615

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

Dr. Campbell  
 50 3615  
 Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James H. Cralle</i>		2. DATE OF DEATH <i>April 16, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1419 Edmondson Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 19-01</i>			
c. Length of stay in Baltimore <i>25 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>1419 Edmondson Ave.</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 2, 1891</i>	9. AGE (In years last birthday) <i>58</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>School</i>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>1419 Edmondson Ave.</i> <i>Mary Jane Cralle</i>	
18. <i>4/20.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>C coronary disease of heart</i> DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-7-1950</i> to <i>4-16-1950</i> that I last saw the deceased alive on <i>4-6-1950</i> and that death occurred at <i>8:45 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>John E. S. Campbell</i>		23B. ADDRESS <i>1639 N. Carey St.</i>		23C. DATE SIGNED <i>4-17-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/21/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bald. Nat'l</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25. FUNERAL DIRECTOR <i>Holland</i>		25. FUNERAL ADDRESS <i>1631 Druid Hill Ave.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 18 1950</i>		REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment



F-460

50 3616

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3616

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Martha Fuller

2. DATE  
OF DEATH

April 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Oct. 10, 1870

9. AGE (In years

last birthday)

70

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR INDUSTRY

Dom. Family

11. BIRTHPLACE (State or foreign country)

Howard Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Augustus Matthews

14. MOTHER'S MAIDEN NAME

Ethel Anna Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Margaret Green Lanvale St

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Cancer of the uterus

INTERVAL BETWEEN ONSET AND DEATH

6 months

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension - vascular disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1949 to April 16, 1950 that I last saw the deceased alive on Apr 15, 1950, and that death occurred at 4:30 AM, from the causes and on the date stated above.

23A. SIGNATURE

Resident H. Mumley, M.D.

23B. ADDRESS

1325 N. Lanvale St.

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/20/1950

24C. NAME OF CEMETERY OR CREMATORY

Western Star

24D. LOCATION (City, town, or county)

Calmarville, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

[Signature] 1051 Druid Hill Ave.

# CERTIFICATE OF DEATH

Form No. 10

U.S. DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

State of NEW YORK  
County of NEW YORK

Date of Death 10/10/1910  
Time of Death 10:00 AM

Place of Death Home

Name of Deceased JOHN J. SMITH  
Age 45 Sex M

Marital Status Married  
Occupation Teacher

Usual Residence 123 Main St., New York City

Cause of Death Heart Disease  
Immediate Cause Myocardial Infarction

Period of Incubation None

Medical History None  
Previous Illnesses None  
Injuries None

Attending Physician Dr. J. H. Smith  
Signature [Signature]

Coroner's Office None  
Signature [Signature]

Medical Examiner None  
Signature [Signature]

Physician None  
Signature [Signature]

Witness None  
Signature [Signature]

Registrar None  
Signature [Signature]

Deputy Registrar None  
Signature [Signature]

Health Officer None  
Signature [Signature]

Sanitary Officer None  
Signature [Signature]

R-250

REAGAN

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3617

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

APRIL 15 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTO. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

WEST BALTO. GENERAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO. Md. 23-01

c. Length of stay in Baltimore

LIFE

D. STREET ADDRESS (If rural, give location)

1001 S. HANOVER ST.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

DEC. 11-1911

9. AGE (In years last birthday)

38 yrs.

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MANAGER

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

11. BIRTHPLACE (State or foreign country)

BALTO Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

GEORGE F. REAGAN

14. MOTHER'S MAIDEN NAME

MARK ANN BRILL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-16-3079

17. INFORMANT

ADDRESS

ANNA E. REAGAN-1001 S. HANOVER ST

18.

E900.61

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

Fracture of skull &amp; intra-cerebral hemorrhage

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Javon

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

4700 Liberty Hgts. Ave. 28/1

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

April 15 1950 10P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down steps

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Royer

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ M.D.

23C. DATE SIGNED 16 April 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

APRIL-19-1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

BALTO.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 18 1950

REGISTRAR'S SIGNATURE

William M. Williams, M.D.

25. FUNERAL DIRECTOR

KRAUSE FUNERAL HOME

ADDRESS

1860

VS 151

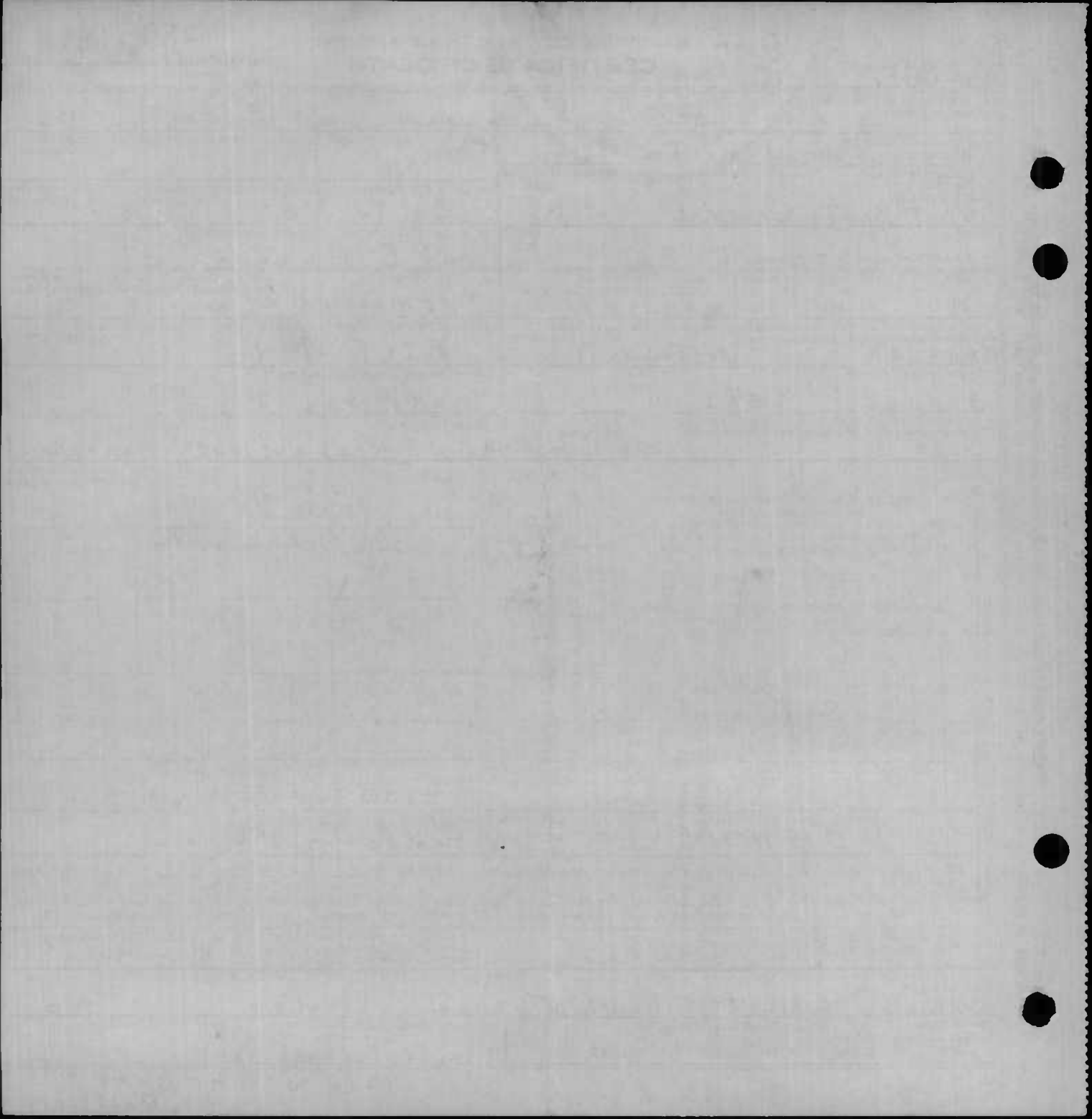
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15671

1216 S. CHARLES ST. BALTO 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully specified. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3618

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **ROSINA PASCARELL** 2. DATE OF DEATH **April 18, 1950**

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  
A. STATE **Ohio** B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location) **US Marine Hospital**  
INSTITUTION **Wyman Pk. Drive & 31st St.** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Warren**

D. STREET ADDRESS (If rural, give location)  
**RD #3 Barkman Rd.** c. Length of stay in Baltimore **12 days** Yrs. \_\_\_\_\_ Mos. \_\_\_\_\_ Days \_\_\_\_\_

5. SEX **F** 6. COLOR OR RACE **W** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **2/2/02** 9. AGE (In years last birthday) **48** 10 Under 1 Year Months: \_\_\_\_\_ Days: \_\_\_\_\_ 11 Under 24 Hours Hours: \_\_\_\_\_ Min: \_\_\_\_\_

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY **At Home** 11. BIRTHPLACE (State or foreign country) **Italy** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **? Unknown** 14. MOTHER'S MAIDEN NAME **? Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **No** (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. **None** 17. INFORMANT ADDRESS **Records- US Marine Hospital, Balto, Md.**

18. **192 X** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Melanoma, malignant right eye (operated 1946)**  
DUE TO **metastatic to the liver**  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
**II**  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
INTERVAL BETWEEN ONSET AND DEATH **3 1/2 yrs**

19A. DATE OF OPERATION **2** 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY \_\_\_\_\_ 21E. INJURY OCCURRED \_\_\_\_\_ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from **Apr. 6**, 19**50**, to **Apr. 18**, 19**50**, that I last saw the deceased alive on **Apr. 18**, 19**50**; and that death occurred at **1:10A** m., from the causes and on the date stated above.

23A. SIGNATURE **John L. Wilson** 23B. ADDRESS **US Marine Hospital, Balto, Md.** 23C. DATE SIGNED **4/18/50**

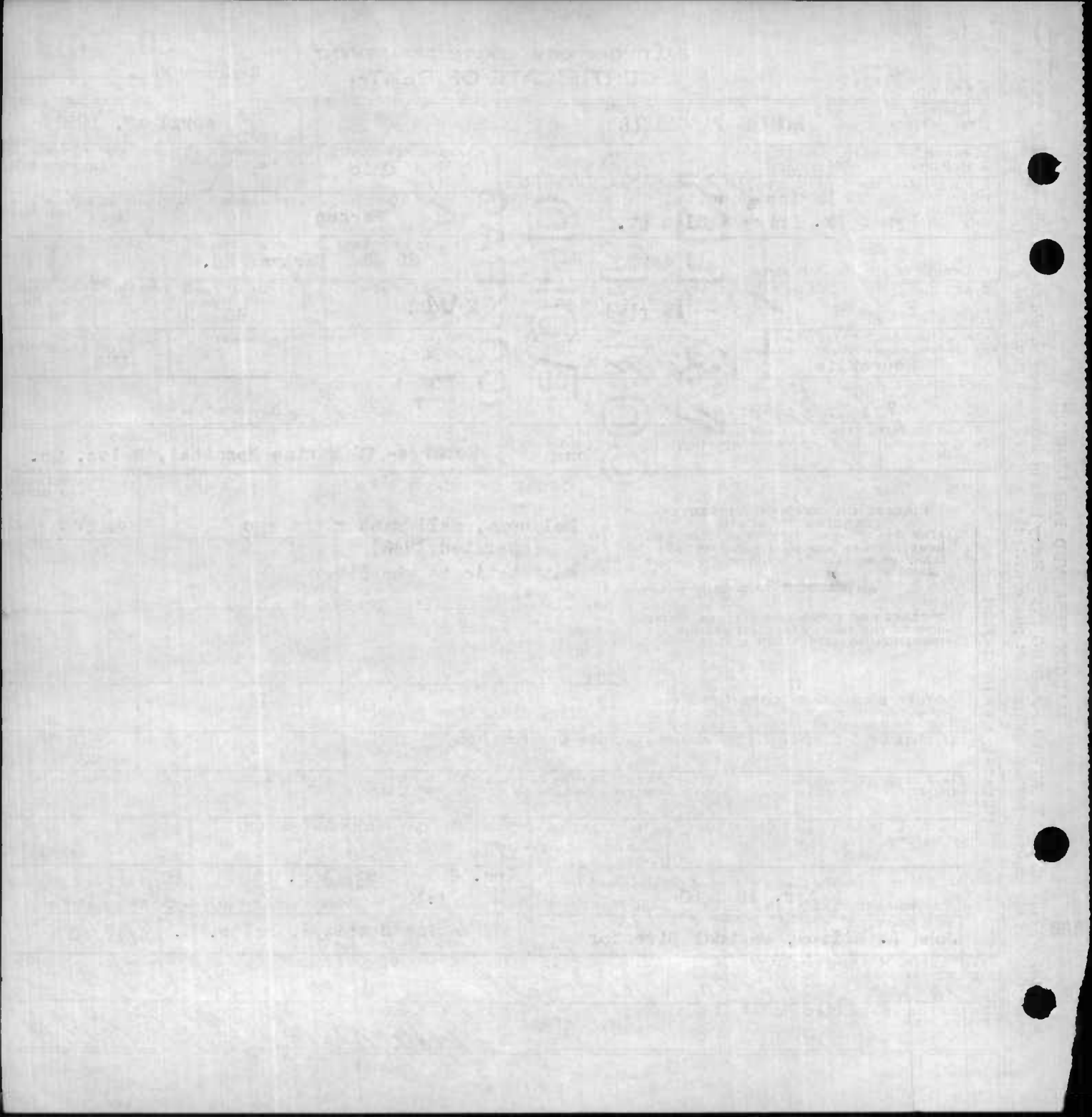
24A. BURIAL, CREMATION, REMOVAL (Specify) **burial** 24B. DATE **4/18/50** 24C. NAME OF CEMETERY OR CREMATORY **New Castle** 24D. LOCATION (City, town, or county) (State) **New Castle Pa.**

DATE RECEIVED BY LOCAL REGISTRAR \_\_\_\_\_ REGISTRAR'S SIGNATURE **William M. ...** 25. FUNERAL DIRECTOR **William M. ...** ADDRESS **1214 ...**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

P-264





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3619

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ANNA T. MILLER

2. DATE  
OF  
DEATH

Apr. 15 - 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

DO 117-S-Fulton Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

19-04

D. STREET ADDRESS (If rural, give location)

117-S-Fulton Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Housewife

At Home

Balto. Md.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Jacob J. Rehner

Mary-E-Scott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

No

None

Edward P. Miller - Son

18. 585 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardio Vascular Disease

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

Chronic Cholecystitis

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 11, 1950, to April 15, 1950, that I last saw the deceased alive on April 15, 1950, and that death occurred at 109 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

Huntington Williams, Jr.

J. B. Whiffert &amp; Son

CONTAINS THE NAME OF THE  
DEPT. OF DEFENSE

50 3620

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3620

Registered No.

BIRTH NO. 50-07613

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Lambert

2. DATE  
OF  
DEATH

April 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

38 University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore #2 3-02

D. STREET ADDRESS (If rural, give location)

1015 E. Pratt St

c. Length of stay in Baltimore

2 Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Newborn

8. DATE OF BIRTH

April 11, 1950

9. AGE (In years  
last birthday)H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.

2 days

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Gordon Shirley Lambert

14. MOTHER'S MAIDEN NAME

Rose Ella Mae Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother

18.

760.0 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Respiratory failure  
Central damage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Probable blunt injury

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 11, 1950, to April 12, 1950, that I last saw the  
deceased alive on April 12, 1950, and that death occurred at 10:32 AM from the causes and on the date stated above.

23A. SIGNATURE

Ann Howant

23B. ADDRESS

University Hospital

23C. DATE SIGNED

April 12, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL APR 18 1950

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

Huntington Williams, M.D.

Commissioner of Health

VS 150

APR 19 1950

160a

CERTIFICATE OF DEPOSIT

DATE OF DEPOSIT

AMOUNT OF DEPOSIT

PERCENTAGE OF INTEREST

DATE OF MATURITY

NAME OF DEPOSITOR

ADDRESS OF DEPOSITOR

NAME OF BANK

ADDRESS OF BANK

CITY OF BANK

STATE OF BANK

COUNTRY OF BANK

DATE OF STATEMENT

NAME OF BANKER

ADDRESS OF BANKER

CITY OF BANKER

STATE OF BANKER

COUNTRY OF BANKER

DATE OF STATEMENT

NAME OF BANKER

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STATE OF BANKER

COUNTRY OF BANKER

DATE OF STATEMENT

NAME OF BANKER

ADDRESS OF BANKER

CITY OF BANKER

STATE OF BANKER

COUNTRY OF BANKER

DATE OF STATEMENT

NAME OF BANKER

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Mary Ellen Smith*

2. DATE  
OF  
DEATH

*April 16, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *1931 E. Fayette St.,*

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

*Maryland.*

B. COUNTY

\_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore*

O. STREET ADDRESS (If rural, give location)

*1931 E. Fayette St.,*

C. Length of stay in Baltimore *lifetime*

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*July 31, 1875*

9. AGE (In years last birthday)

*74*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*At home*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*John Barnsby*

14. MOTHER'S MAIDEN NAME

*Jane Agar*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No.*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Hazel Smith 3300 Westfield Ave.*

18. *4/20/50*

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Acute Cardiac Failure*

DUE TO

*1/2 hr.*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Arteriosclerotic Heart Disease*

DUE TO

*5 yrs.*

(C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *April 27, 1949* to *April 16, 1950* that I last saw the deceased alive on *April 14, 1950* and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

*Israel Rosen*

23B. ADDRESS

*24138 Monument St*

23C. DATE SIGNED

*4/17/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*Apr. 19, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Baltimore National*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, Jr.*

25. FUNERAL DIRECTOR

ADDRESS

*Ullrich Funeral Home 2008 Orleans St.,*

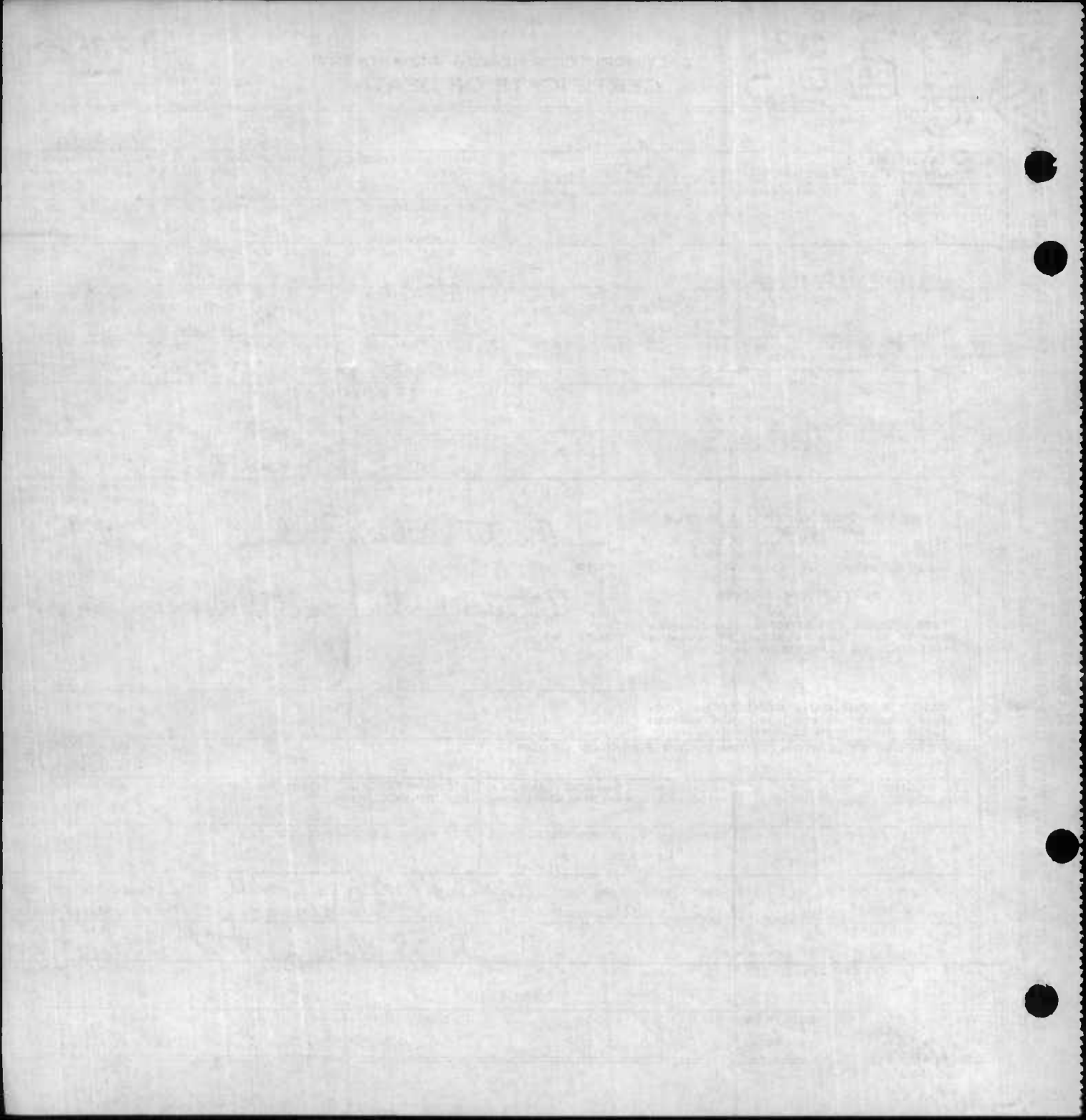
*937*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

APR 18 1950  
APR 19 1950  
APR 19 1950







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Eva Schmidt Straub*

2. DATE  
OF  
DEATH

*April 17, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *5110 Pinewood Ave.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *Maryland*

B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 27-05*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

*3110 Pinewood Ave.*

5. SEX

*Female*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Widowed*

8. DATE OF BIRTH

*July 5, 1883*

9. AGE (In years last birthday)

*66*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*At home*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Hungary*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Nicholas Schmidt*

14. MOTHER'S MAIDEN NAME

*Emma Harlauer*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No.*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Evelyn K. Niedling 3110 Pinewood Ave.*

18.

*4/20.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

*Coronary Heart Disease*

INTERVAL BETWEEN ONSET AND DEATH

*6 wks.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

*Hypertensive C. V. Disease*

(C)

*Arteriosclerosis*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Nov. 1949*, to *Apr. 17, 1950*, that I last saw the deceased alive on *Apr. 17, 1950*, and that death occurred at *1:45 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Nathan Janney*

23B. ADDRESS

*7101 Harford Rd.*

23C. DATE SIGNED

*4/17/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*Apr. 20, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Cross*

24D. LOCATION (City, town, or county)

*Brooklyn, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, MD*

25. FUNERAL DIRECTOR

ADDRESS

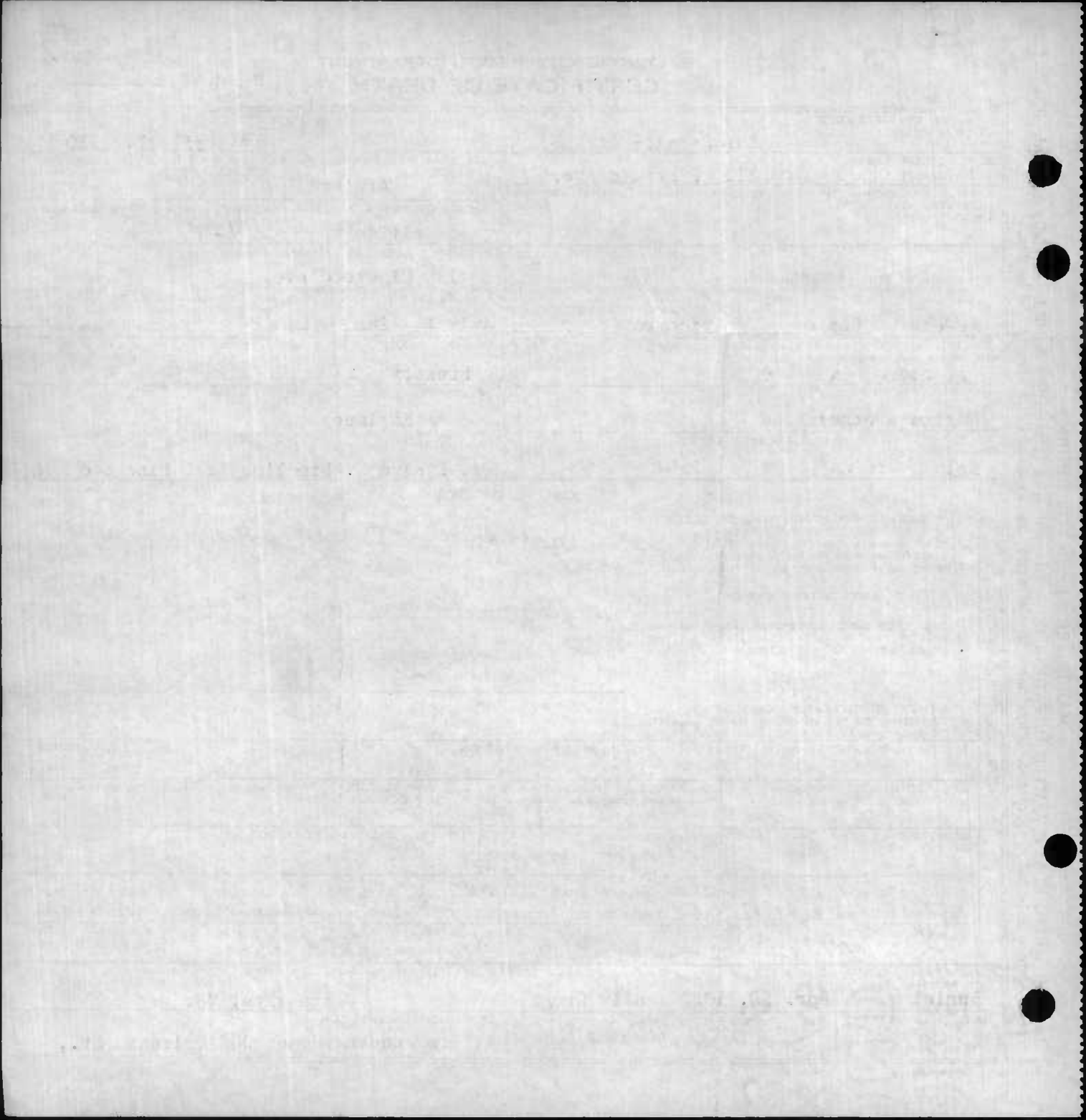
*Ullrich Funeral Home 2008 Orleans St.,*

VS 130

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



R-200  
50 3623ROESCKE  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3623  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth Roescke

2. DATE  
OF  
DEATH

4/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

AMBERLEY

4702 W. Amberley Ave

66

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4702 W. Amberley Ave

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct 10, 1882

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR  
INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Zehnter

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Minnie H. Frost 4702 Amberley Ave

18.

422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Autoaccident C.V. disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

P. C. Lubinski

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/12/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

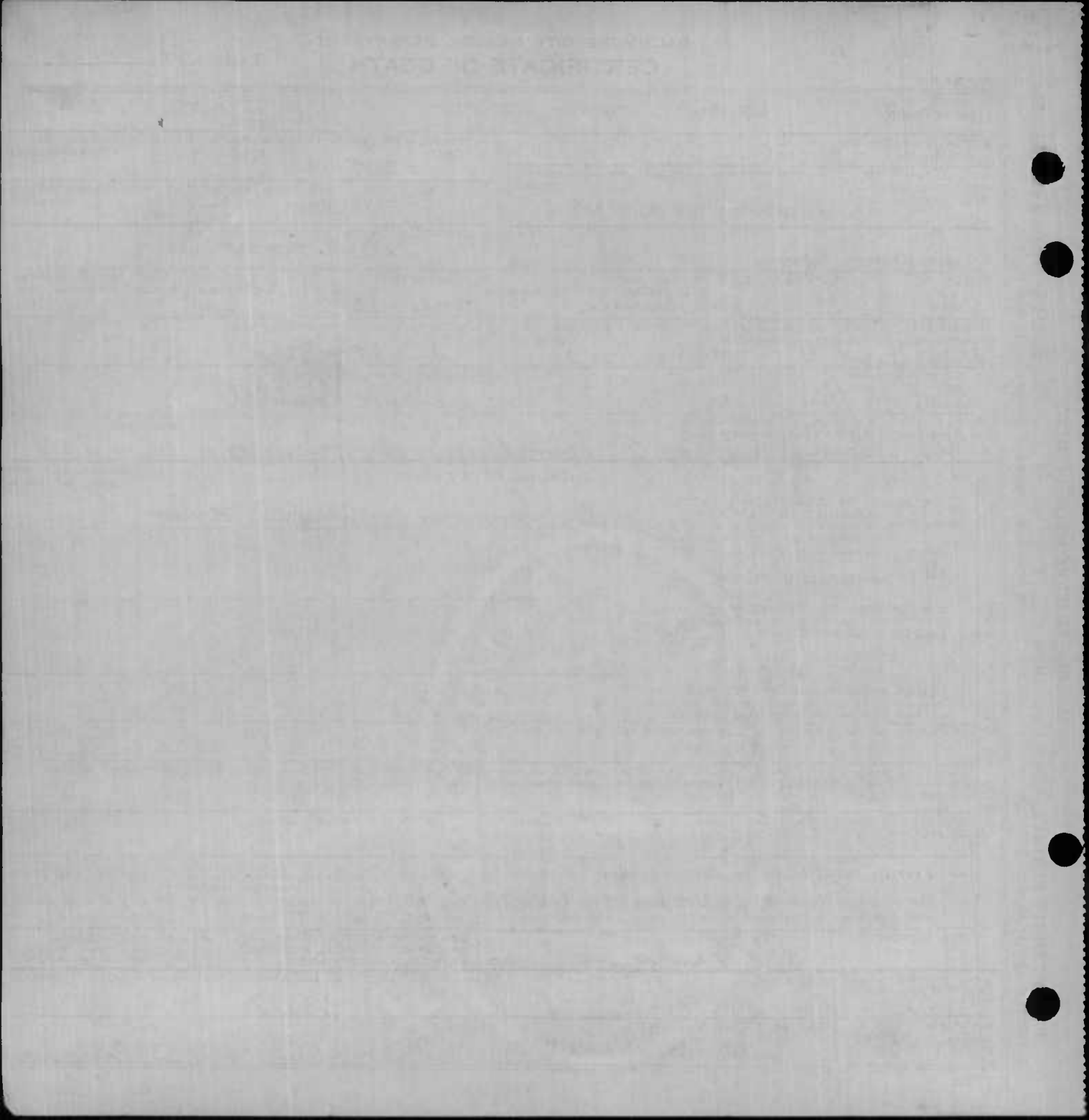
ADDRESS



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 3624	
CERTIFICATE OF DEATH					
BIRTH NO. 3624					
1. NAME OF DECEASED (Type or Print) Louis Ernest Schroeter			2. DATE OF DEATH April 18, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-63		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 2333 E. Monument St.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan 11, 1880	9. AGE (In years last birthday) 70	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY Moose Hall		11. BIRTHPLACE (State or foreign country) Bald Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frank B. Schroeter		14. MOTHER'S MAIDEN NAME Sophie Oetzel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Spanish American 217-09-5440A		17. INFORMANT Emilie S. Hochstrassen Rwa. 996 Md	
18. 443 X			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) Hypertensive Cardiovascular Disease		
ANTECEDENT CAUSES			(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			DUE TO		
II			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE R. Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED April 18, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr 19-1950		24C. NAME OF CEMETERY OR CREMATORY Western	
24D. LOCATION (City, town, or county) (State) Bald Md		25. FUNERAL DIRECTOR Mrs. John N. Teufel & Son		ADDRESS 5311 Edmondson	
DATE RECEIVED BY LOCAL REGISTRAR APR 19 1950		REGISTRAR'S SIGNATURE William M. ...		71094	
VS 151		APR 19 1950		937 Vave	





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3625

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EVERETT WILEY

2. DATE  
OF  
DEATH

4/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 11-04

D. STREET ADDRESS (If rural, give location)

303 W. Lenoire St #17

C. Length of stay in Baltimore since 1939 off on

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hosp. Records.

18.

331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

TH.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/18/50 to 4/18/50, that I last saw the deceased alive on 4/18/50, and that death occurred at 12:00 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 19 1950

Huntington Williams, M.D.

Joseph Larose Inc. 2013 Greenmount Ave.

APR 19 1950

944995 626

83a

STATE OF ILLINOIS  
CERTIFICATE OF DEATH

FILE NO. 100-100000  
JAN 1 1900

NAME OF DECEASED  
JAMES M. HARRIS

DATE OF DEATH  
JAN 1 1900

PLACE OF DEATH  
CHICAGO, ILL.

AGE  
45

SEX  
MALE

OCCUPATION  
CLOCKMAKER

CAUSE OF DEATH  
HEART DISEASE

PLACE OF BIRTH  
NEW YORK, N.Y.

EDUCATION  
HIGH SCHOOL

RELIGION  
METHODIST

DATE OF BURIAL  
JAN 1 1900

PLACE OF BURIAL  
MOUNT RAINIER CEMETERY

NAME OF FUNERAL HOME  
HARRIS & SONS

NAME OF MINISTER  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

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JAMES M. HARRIS

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JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

NAME OF CLERGYMAN  
JAMES M. HARRIS

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3626

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA COMBS

2. DATE  
OF  
DEATH

April 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1708 Eutaw Place

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Middle River

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Aug. 1, 1863

9. AGE (In years  
last birthday)

86

If Under 1 Year  
Months: Days: If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At. Home

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Richard Rogers

14. MOTHER'S MAIDEN NAME

Sarah Snellings

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Margaret Wiatrowski, Middle River, Md.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

CAUSE OF DEATH

Cerebral Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Atherosclerosis  
Adv. Rheumatoid ArthritisINTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 31, 1950, to April 17, 1950, that I last saw the deceased alive on April 17, 1950, and that death occurred at 9 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Louis Sgarbi

23B. ADDRESS

1700 Eutaw Place (17)

23C. DATE SIGNED

4-18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/21/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel

24D. LOCATION (City, town, or county)

Baltimore County, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, Md.

25. FUNERAL DIRECTOR

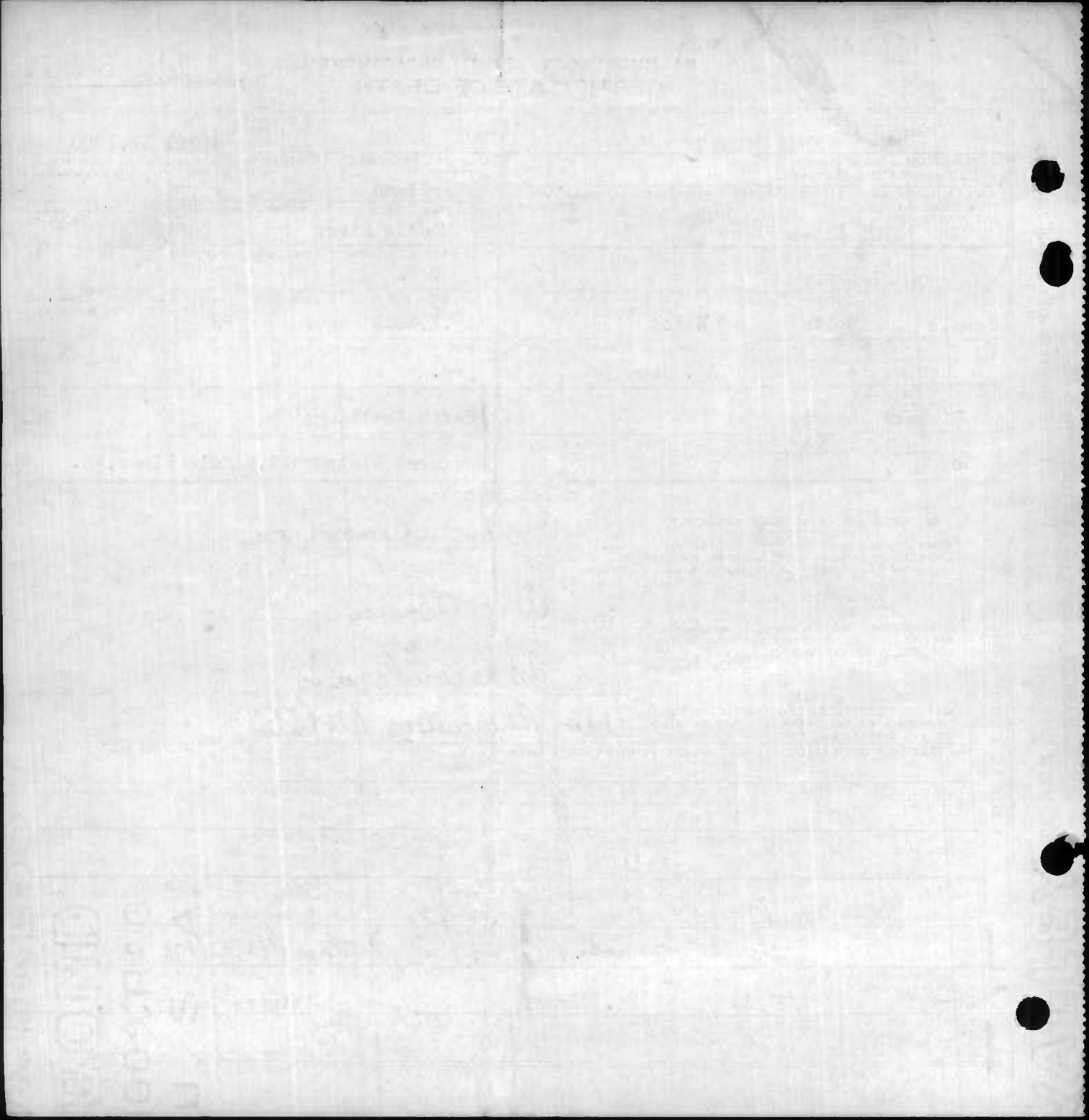
ADDRESS

William G. G. Inc. 1214 S. Paul St.

VS 150

APR 18 1950  
APR 19 1950

83a



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3627

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Doris H. DeLisle

2. DATE  
OF  
DEATH

4/17/50

3. PLACE OF DEATH:

A. Baltimore City Maryland

B. FULL NAME OF (If not in hospital) or institution, give street address or location

Md Gen Hosp

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 11-04

D. STREET ADDRESS (If rural, give location)

922 Madison Ave

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb 25, 1909

9. AGE (In years  
last birthday)

41

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At home

11. BIRTHPLACE (State of foreign country)

Crisfield Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John A Ward

14. MOTHER'S MAIDEN NAME

Sally Croft

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 022X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

## CAUSE OF DEATH

Rupture of aortic aneurysm

Septic Cardis - Vascular Disease

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspector thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William G. Helbach

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/2/50

24C. NAME OF CEMETERY OR CREMATORY

Woburn

24D. LOCATION (City, town, or county) (State)

Crisfield Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

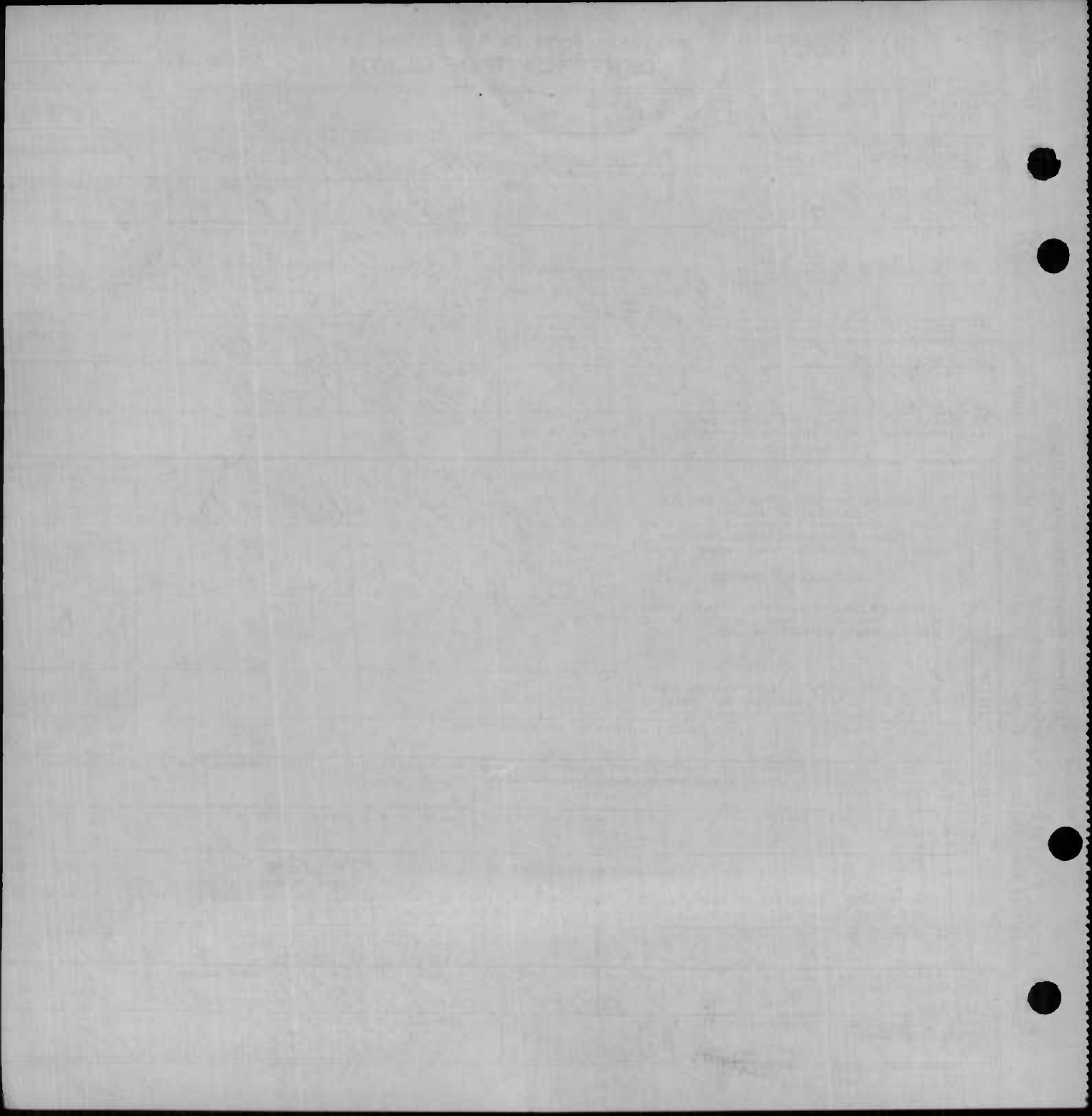
25. FUNERAL DIRECTOR

William G. Helbach 12195 Con

VS 151

APR 19 1950

30E





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MS--123205

50

3628

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50

3628

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Barbara Schwartz

2. DATE  
OF  
DEATH

4-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3803 Mt. Pleasant Ave. Zone 24

c. Length of stay in Baltimore

life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Mar. 19, 1869

9. AGE (In years  
last birthday)

81

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At. Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Bien

14. MOTHER'S MAIDEN NAME

Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records\*4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Hemorrhage from large bowel

DUE TO

ANTECEDENT CAUSES

(B) Diverticulosis or ulcerative colitis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Generalized arteriosclerosis

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23-\_\_\_\_, 1948 to 4-18-\_\_\_\_, 1950 that I last saw the  
deceased alive on 4-18-\_\_\_\_, 1950, and that death occurred at 9:30A m., from the causes and on the date stated above.

23A. SIGNATURE

H. C. Cogan

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/21/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Parkville

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

William Cogan 1219 St Paul St

VS 150

APR 19 1950

97



50 3629

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3629

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillie Maude Towner

2. DATE  
OF  
DEATH

April 18 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3520 Hilton St

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE B. COUNTY  
3520 N. Hilton St Balto MdB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Shriner Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore West Chester

D. STREET ADDRESS (If rural, give location)

3520 N. Hilton St V-25

c. Length of stay in Baltimore

21 Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Jan 24 1875

9. AGE (In years,  
last birthday)

75

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William B. Lyons

14. MOTHER'S MAIDEN NAME

Mary I Burley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Nettie T. Stehley 4022 Belle Ave

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/28, 1949, to 4/18, 1950, that I last saw the  
deceased alive on 4/18, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Apr 21 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

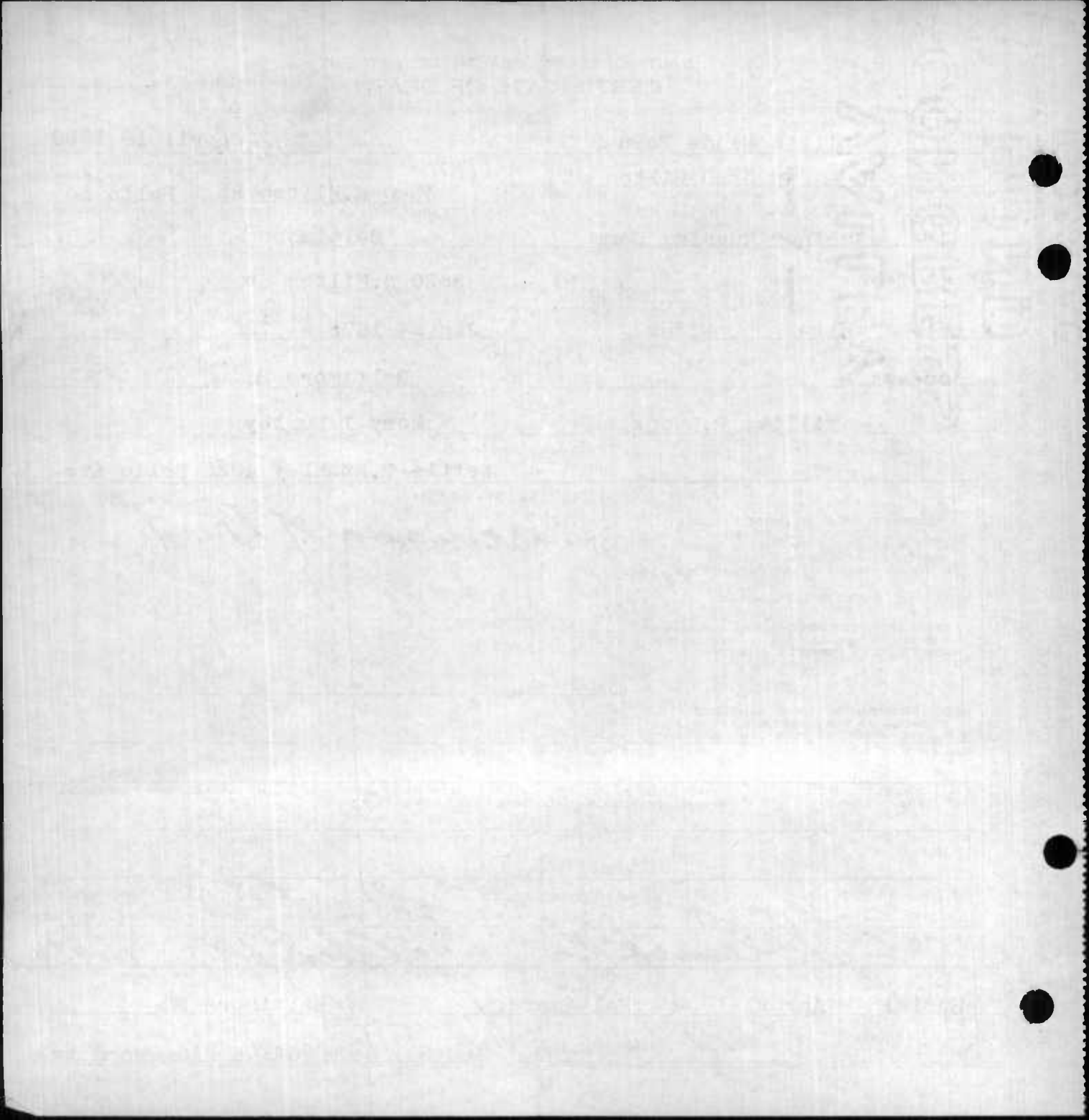
APR 9 1950

Thurston Williams, M.D.

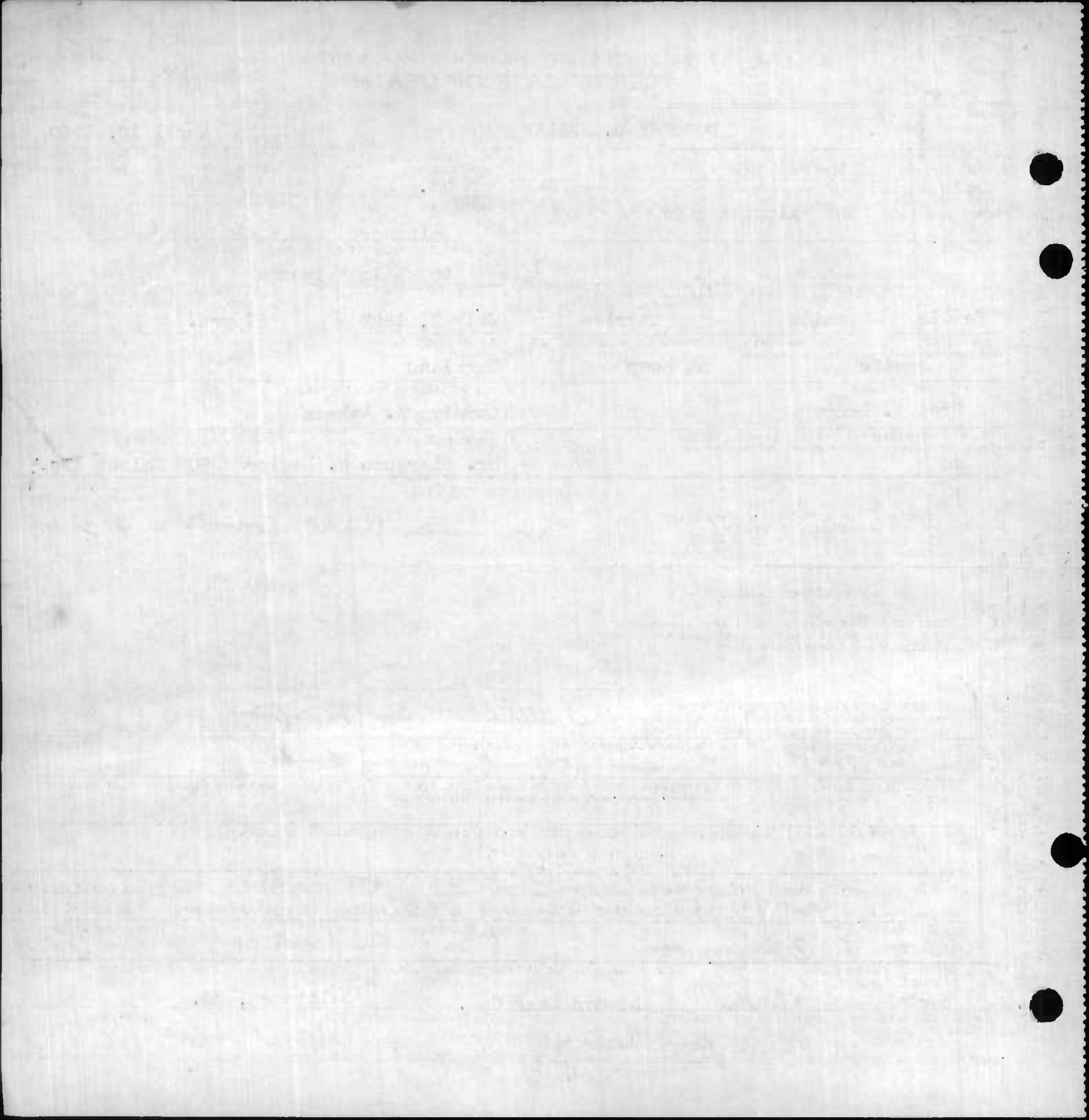
25. FUNERAL DIRECTOR

4204 Ridgewood Ave

50









50 3631

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3631

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FLORENCE LEBER SCHULTZ

2. DATE  
OF  
DEATH

Apr. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1502 Shadyside Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore (Northwood) 9-02

D. STREET ADDRESS (If rural, give location)

1502 Shadyside Road

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

June 4, 1873

9. AGE (In years  
last birthday)

76

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Jacob H. Leber

14. MOTHER'S MAIDEN NAME

Emma Tilyard

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
no

17. INFORMANT

ADDRESS

Mr. Paul Leber - Homewood Apts. Chas. &amp; 31st

18.

4/20/50

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

(A) Arteriosclerotic Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

Several years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Generalized Arteriosclerosis

Indefinite

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 17 April, 1950, to 17 April, 1950, that I last saw the deceased alive on 17 April, 1950, and that death occurred at 7:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

261 E. Belvedere Ave

18 April 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4/20/50

Lorraine Cem.

Woodlawn, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 18 1950

Huntington Williams, M.D.

Wm. J. Tichener &amp; Sons, Baltimore, Md.

VS 150

APR 19 1950

937

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Sex		Race	
Marital Status		Cause of Death	
Occupation		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Signature		Date of Signature	

MARGIN RESERVED FOR BINDING

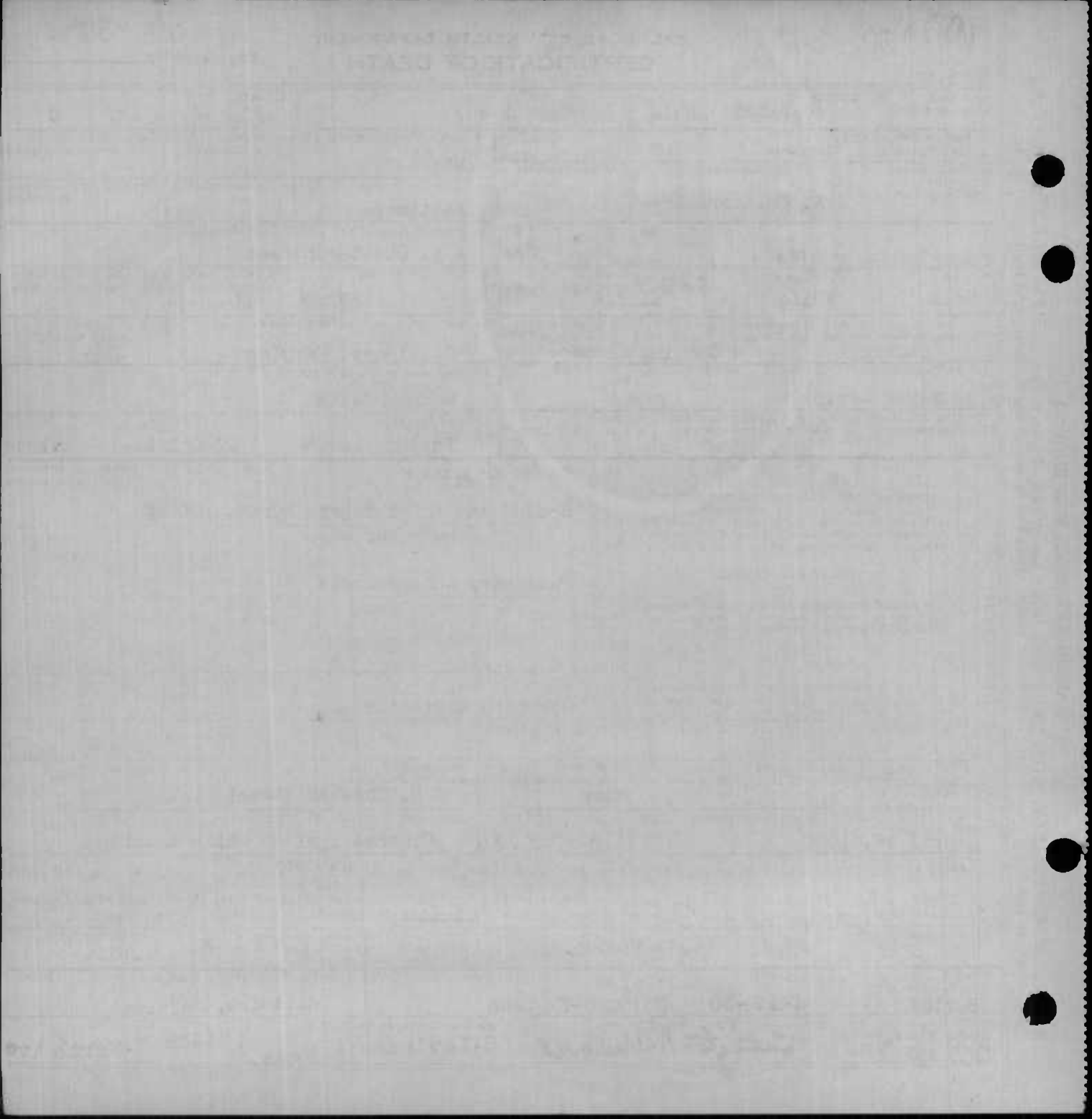
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT				50 3632	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) HARRY LEWIS (SAMUEL LEVIN)			2. DATE OF DEATH April 18, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		
B. FULL NAME OF HOSPITAL OR INSTITUTION 4 N. Chester Street			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-04		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 4 N. Chester Street		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 1892	9. AGE (In years last birthday) 58	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Canning Company	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Meyer Levin			14. MOTHER'S MAIDEN NAME Hannah Saltz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Isidore Levin 2460 Lakeview Avenue		
18. E916.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Second and third degree burns, 50% of body surface DUE TO Pulmonary tuberculosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO Morphine addiction OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4 N. Chester Street House not 6/4	
21D. TIME (Month) (Day) (Year) (Hour) April 18, 1950 ? m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Clothes ignited while smoking	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death is my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE E. L. Royer		23B. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER		23C. DATE SIGNED 4-19-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-19-50		24C. NAME OF CEMETERY OR CREMATORY Mickro-Kodesh	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. FUNERAL DIRECTOR S. Levinson & Bros.		24F. ADDRESS 1124-26 W. North Ave	
DATE RECEIVED BY LOCAL REGISTRAR APR 19 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.			

N-948.2 988 X1

181



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

520

50 3633

Susan Young

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 3633

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived before admission):  
A. STATE Md.  
B. COUNTY Baltimore

5. LENGTH OF STAY IN BALTIMORE Life

6. SEX Female

7. COLOR OR RACE Negro

8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

9. DATE OF BIRTH 9/19/1890

10. AGE (In years last birthday) 59

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT Johns Hopkins Hospital

18. 443X I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
CAUSE OF DEATH  
Central hemonhage (left)  
DUE TO  
II  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO  
Hypertensive C-V disease  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 16, 1950 to Apr. 16, 1950, that I last saw the deceased alive on Apr. 16, 1950, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE Susan Calver

23B. ADDRESS Johns Hopkins Hospital

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 4/20/1950

24C. NAME OF CEMETERY OR CREMATORY Mt Calvery Cem.

24D. LOCATION (City, town, or county) (State) Brooklyn A.A.Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR APR 19 1950

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Elroy O. Wilson

ADDRESS 1000 Brantly Ave

VS 150

APR 19 1950

937

CERTIFICATE OF DEATH

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



50 3634

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3634

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OTTO GEORGE JAHN

2. DATE  
OF  
DEATH

APRIL 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland BALTIMORE, MD.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

6028 OLD HARFORD ROAD

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2035 SINCLAIR LANE

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWER

8. DATE OF BIRTH

JULY 15, 1873

9. AGE (in years  
last birthday)

76

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

- - - -

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PIPE FITTER - RET.

10B. KIND OF BUSINESS OR  
INDUSTRYINDUSTRIAL  
STEAM INSTALLATIONS

11. BIRTHPLACE (State or foreign country)

NORWAY

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

NO

16. SOCIAL  
SECURITY NO.

314-01-7553

17. INFORMANT

ADDRESS

MRS. ESTHER C. BURTON, LUTHERVILLE, MD.

18. 421.4 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A)

Cerebral Embolus

INTERVAL BETWEEN  
ONSET AND DEATH

18 hrs

DUE TO

(B)

Cardiac decompensation

2 mos.

DUE TO

(C)

Valvular Heart disease

1 week

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21/50, to 4/17/50, that I last saw the  
deceased alive on 4/17/50 and that death occurred at 11:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Bennett G. Stoen

M. D.

23B. ADDRESS

Lutherville,

23C. DATE SIGNED

4/18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

April 20, 1950

24C. NAME OF CEMETERY OR CREMATORY

PROSPECT HILL CEM.

24D. LOCATION (City, town, or county)

TOWSON, MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Lutherville, MD.

25. FUNERAL DIRECTOR

ADDRESS

JOHN BURNS &amp; SONS, TOWSON, MD.

RECEIVED  
JAN 15 1958  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES

LOUGHRAN

2. DATE  
OF  
DEATH

April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

700 W. Baltimore Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

9. AGE (In years  
last birthday)

49

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Owen Harratty 3103 June Oak Place 14 Balto.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Emil L. Ryan M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/17/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/19/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart

24D. LOCATION (City, town, or county)

Baltimore Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeller, One Balto 3rd

VS 151

29865

94a

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,  
January 10, 1907.

REPORT  
OF THE  
COMMISSIONER OF  
THE LAND OFFICE  
FOR THE YEAR  
1906.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully studied. The

50 3636

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3636  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Lda Pennick*

2. DATE  
OF  
DEATH

*April 18, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*22 W. W. Cl.*

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

*JOHNS HOPKINS HOSPITAL*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

*Md.*

B. COUNTY

*St. Mary*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*5-18-1892*

9. AGE (In years  
last birthday)

*55*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Md*

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Jesse Pennick*

14. MOTHER'S MAIDEN NAME

*Ellen Cutchman*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

*JOHNS HOPKINS HOSPITAL*

ADDRESS

18.

*171X*

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

*Hemorrhage*

(A)

*Epidermoid Carcinoma Cervix*

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

*24 hrs*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

*Epidermoid Carcinoma Cervix*

DUE TO

*1 year*

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐

NOT WHILE ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-17-*, 19*50* to *4-18-*, 19*50*, that I last saw the  
deceased alive on *4-18-*, 19*50*, and that death occurred at *5:00* a. m., from the causes and on the date stated above.

23A. SIGNATURE

*Robert P. O'Donnell*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*4-19-50*

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

*Burial*

24B. DATE

*4/2/50*

24C. NAME OF CEMETERY OR CREMATORY

*ZION FAIR*

24D. LOCATION (City, town, or county)

*HERMANVILLE MD.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

*APR 19 1950*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Jos. C. MATTINGLEY LEONARDTOWN*

ADDRESS

*48a MD.*

MEDICAL CERTIFICATION

VS 150  
APR 19 1950





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 3637

## 1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
- (b) Street address 438 Cummins Ct
- (c) Hospital or institution: 00
- (d) Length of stay in hospital or inst. (yrs., mos., or days) —
- (e) Length of stay in Baltimore (yrs., mos., or days) Life

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MD (b) County — 11-04
- (c) City or town Balti MD  
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 438 Cummins Ct  
(If rural give location)
- (e) Citizen of foreign country? No (Yes or No)  
If yes, name country —

## 3 (a) FULL NAME

- (b) If veteran, name war U.S. Navy Spanish American
- (c) Social Security Account No. —

4. Sex M 5. Color or race Col 6 (a) Single, married, widowed, or divorced. Married

- 6 (b) Name of husband or wife Mary Armstrong
- 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 5, 1880

8. AGE: Years 69 Months 11 Days 5 If less than one day — hr. — min.

9. Birthplace Balti MD.  
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Stone

12. Name Purnell Armstrong

13. Birthplace unknown

14. Maiden Name Armi?

15. Birthplace unknown

- 16 (a) Informant Mary Armstrong

- (b) Address 438 Cummins Ct

- 17 (a) Burial (b) Date thereof April 20, 1950  
(Burial, cremation, or removal) (month) (day) (year)

- (c) Cemetery or crematory Baltimore National Cem.  
Location Baltimore, Md

- 18 (a) Funeral director Mr. Kate R. Williams

- (b) Address 322 N. Schroeder St

- 19 (a) 4/18/50 (b) John Williams, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 50, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 49, to April 16 19 50, and that I last saw him alive on April 14 19 50.

- Immediate cause of death Carcinoma Prostate

- Due to Metastasis to liver & ascites

- Due to —

- Other Conditions Chronic Nephritis

- (Include pregnancy within 3 months of death)

- Date of operation none

- Major findings of operation: —

- of autopsy: No

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide

- (b) Date of occurrence — at — M

- (c) Where did injury occur? — City or town (County) (State)

- (d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —  
(Specify type of place)

- (e) Means of injury Ralph & Young

23. Signature Ralph & Young

- Address 1424 Chestnut Date signed 4/17/50

- M. D. —

- 75081

- 51B

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

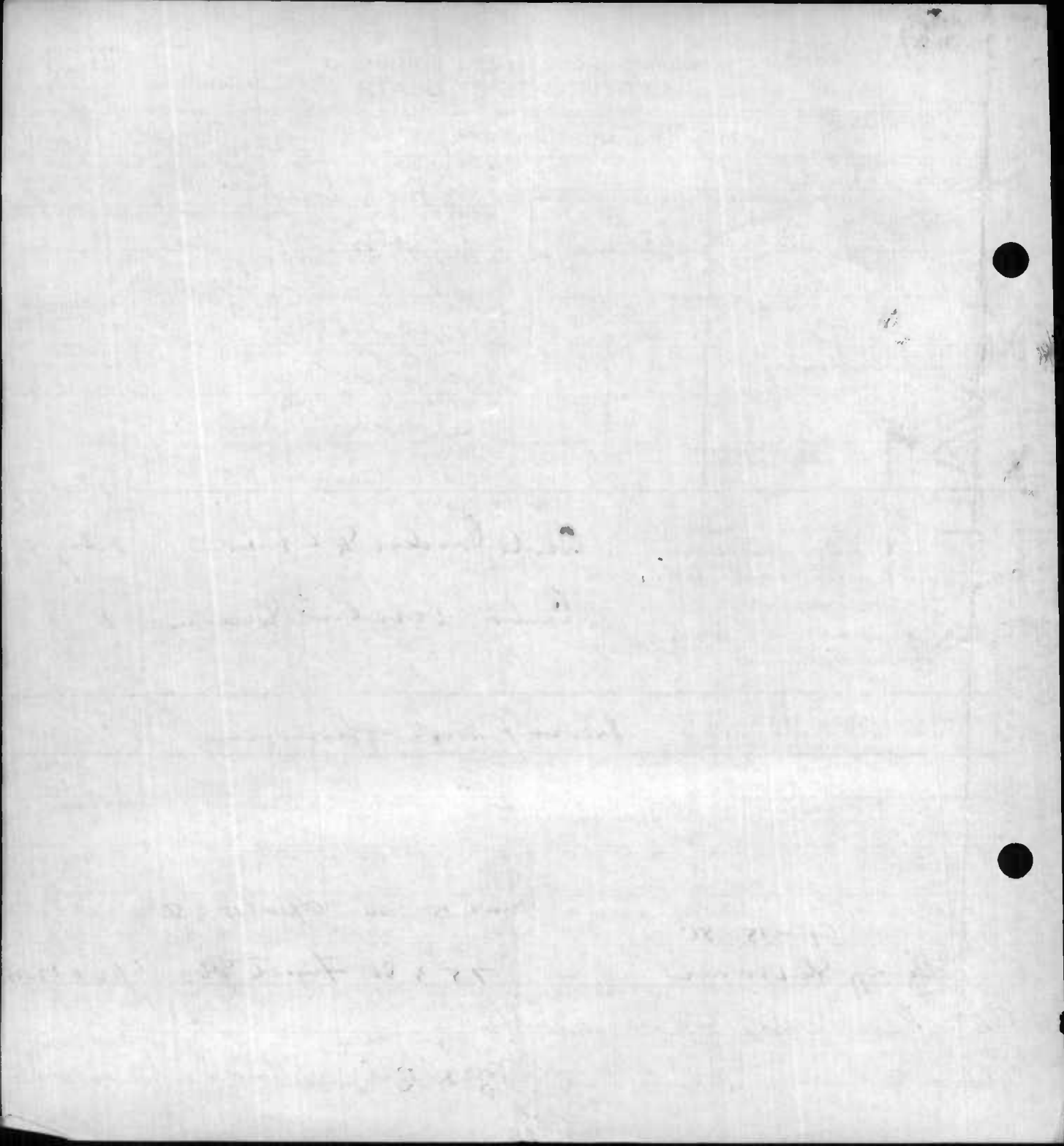
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information correct age is especially important. Physicians: please write the causes of death clearly and legibly.

350  
50 3638

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3638  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cora Thomas Eaton.</i>		2. DATE OF DEATH <i>April 17, 1950.</i>	
3. PLACE OF DEATH: A. <i>Baltimore City, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland.</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>851 Price St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 17-03</i>			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>851 Price St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Nov. 25, 1906</i>	9. AGE (In years last birthday) <i>43</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Jackson, N. C.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca Grant.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Willie Blunt, Boykin, Route 1</i>	
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO		CAUSE OF DEATH (A) <i>Acute Cardiac Dehydration</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		(B) <i>Cardio-vascular Disease</i>		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO		<i>Fluency with effusion</i>		?	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Mar 15, 1950</i> to <i>April 15, 1950</i> that I last saw the deceased alive on <i>April 15, 1950</i> and that death occurred at <i>m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Henry Glusman</i>		23B. ADDRESS M. D. <i>753 E. Fayette St.</i>		23C. DATE SIGNED <i>April 17, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>April 20, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Branchville</i>	
24D. LOCATION (City, town, or county) (State) <i>Virginia</i>		24E. FUNERAL DIRECTOR <i>Mrs. Katie R. Williams</i>		24F. ADDRESS <i>322 N. Schenck St.</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered so clearly and legibly, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3639  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HORACE

BYRD

2. DATE  
OF  
DEATH

April 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

504 Pearl Street

Length of stay in Baltimore  
Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

504 Pearl Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

Jan 1, 1900

9. AGE (In years last birthday)

50

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

Store

11. BIRTHPLACE (State or foreign country)

Petersburg, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Albert Byrd

14. MOTHER'S MAIDEN NAME

Rosie L. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-12-4928

17. INFORMANT

Beatrice Taylor, 504 Pearl St.

ADDRESS

18. 260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Royer

M.D.

23b. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

MEDICAL INVESTIGATOR

23c. DATE SIGNED

17 Apr 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Shipped

24B. DATE

April 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Petersburg

24D. LOCATION (City, town, or county) (State)

Virginia

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

McKatie R. Williams

ADDRESS

322 N

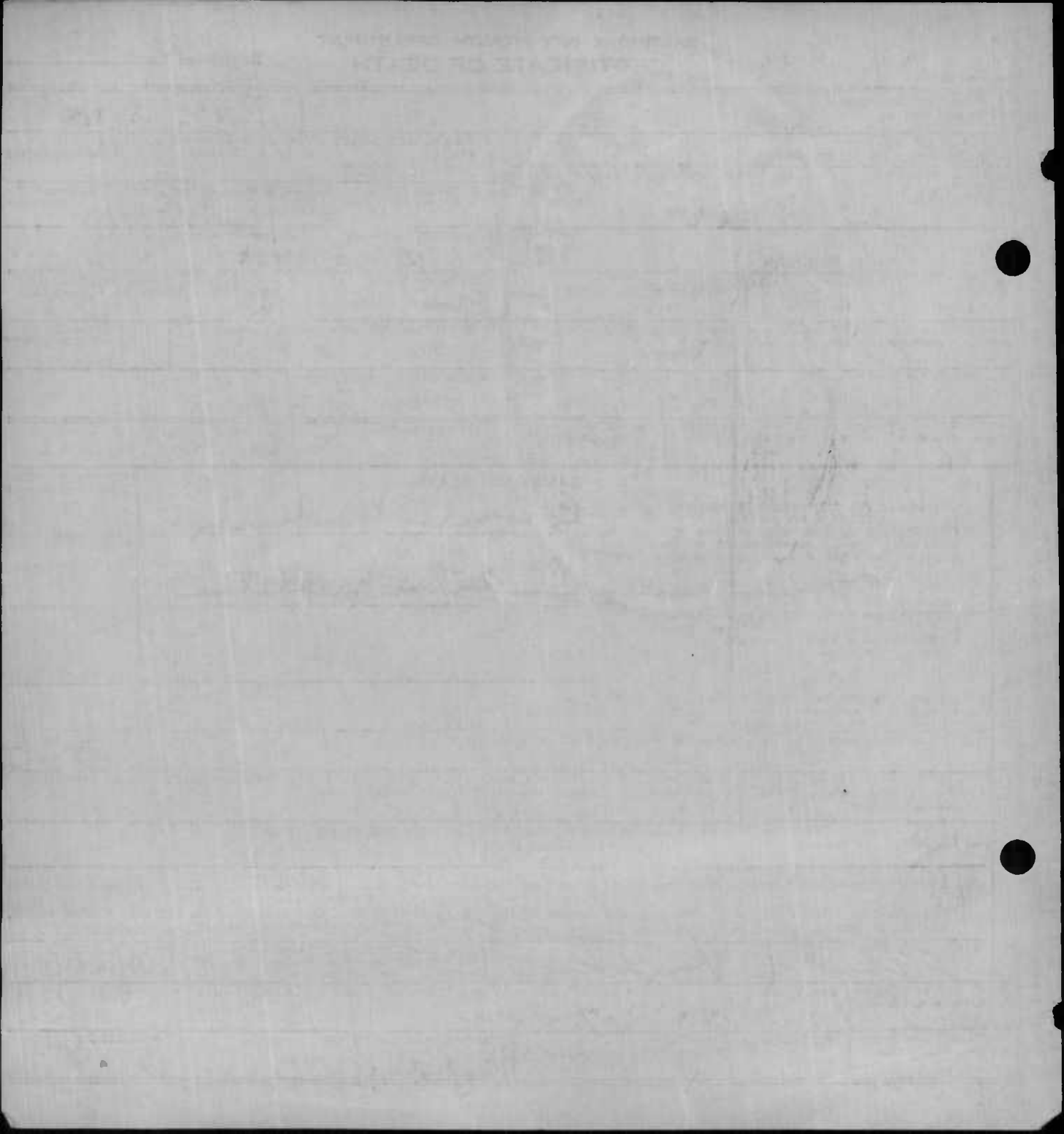
DATE RECEIVED BY LOCAL REGISTRAR

191950

191950

750 79

61





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-416

50 3640

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3640  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Walter R. Woolford</b>		2. DATE OF DEATH <b>4/16/50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland 3202 Lake Ave.</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-03</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>3202 Lake Ave</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Mar 13, 1915</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Coast Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>	9. AGE (In years last birthday) <b>35</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Walter R. Woolford (deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Shawen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Helen Woolford 3202 Lake Ave.,</b>		ADDRESS <input checked="" type="checkbox"/>	

MEDICAL CERTIFICATION

18. <b>415X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocarditis</b> DUE TO ANTECEDENT CAUSES <b>Pneumonic fever</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>	INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>marked</b>
---	---

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION <b>-</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>-</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>-</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>-</b>
22. I hereby certify that I attended the deceased from <b>June</b> , 19 <b>47</b> , to <b>April 16</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-16</b> , 19 <b>50</b> , and that death occurred at <b>9:50 A.M.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>D. W. Moore</b> M. D.	23B. ADDRESS <b>3105 Belair Rd</b>	23C. DATE SIGNED <b>4-17-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/19/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>North Ave. Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 19 1950</b>		25. FUNERAL DIRECTOR <b>Schimunek Funeral Home Inc.</b> <b>2601-03-05 E. Madison St.</b>	
REGISTRAR'S SIGNATURE <b>Washington Williams</b>		ADDRESS	

APR 19 1950

32697

93c

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3641

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Jackson

2. DATE  
OF  
DEATH

April 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence  
A. STATE B. COUNTY before admission)

md

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

00 2330 Penna ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto

15-01

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2330 Penna ave

5. SEX

m

6. COLOR OR RACE

c

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

march 4, 1900

9. AGE (in years,  
last birthday)

50

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ada Day 2330 Penna ave

18. 442 X 002 X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Cardio Renal Disease

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

1 yr.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Pulmonary Tuberculosis

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-12-1950, to 4-18-1950, that I last saw the  
deceased alive on 4-18-1950, and that death occurred at 12 PM, from the causes and on the date stated above.

23A. SIGNATURE

John Jackson

M. D.

23B. ADDRESS

600 W. Calverton Avenue

23C. DATE SIGNED

4/19/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-21-50

24C. NAME OF CEMETERY OR CREMATORY

mt auburn

24D. LOCATION (City, town, or county)

md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

George S. Nelson 1303 Pressman

APR 19 1950

APR 19 1950

96899

13 B

SEE DOCUMENT FILE 50-3641

9-15-50

EW

59-10010

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3642**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

VINCENT Lee WILLIAMS

2. DATE  
OF  
DEATH

April 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

3328 Clifton Avenue Clifftmont Ave.

C. Length of stay in Baltimore

30 yrs

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Nov. 12, 1895

9. AGE (In years  
last birthday)

54

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY  
Yellow Cab Co.

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

William G. Williams

14. MOTHER'S MAIDEN NAME

Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WWI

16. SOCIAL  
SECURITY NO.

219-18-3203

17. INFORMANT 3328 Clifftmont Avenue

Mrs. Flora E. Williams

18.

4/20.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☐  
M.D. MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
4-19-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

4/21/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Park Cemetery Baltimore, Md.

24D. LOCATION (City, town, or county)

(State)

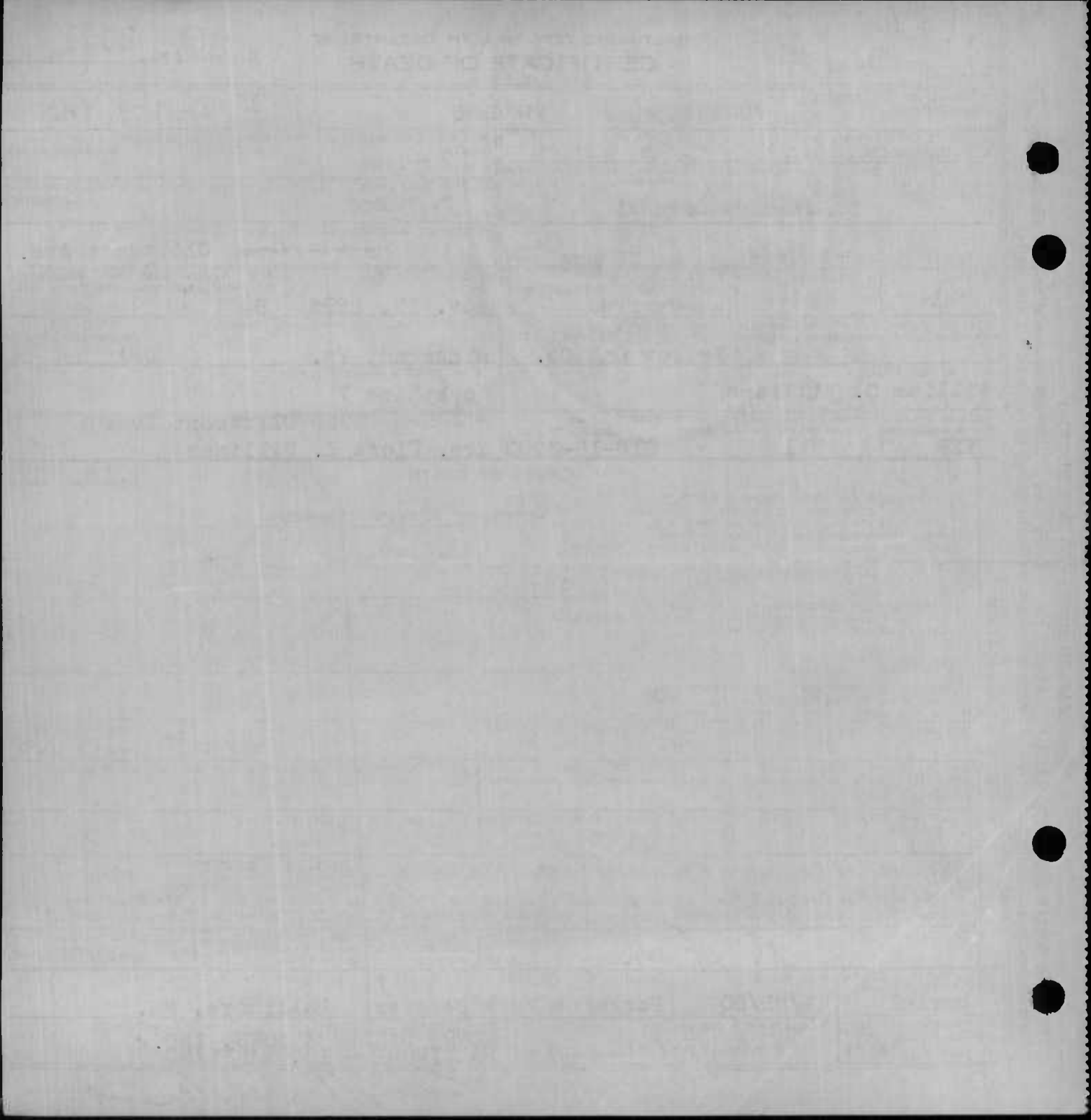
DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
BALTIMORE - 13, MARYLAND





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 3643BIRTH NO. 50-49-276991. NAME OF DECEASED  
(Type or Print)KAREN MARY OSTERMANN2. DATE  
OF  
DEATHAPRIL 18 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

MARYLAND.B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONSINAI HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE8-06

c. Length of stay in Baltimore

LIFEYrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1707 E FEDERAL STREET.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)SINGLE

8. DATE OF BIRTH

DEC 26 19499. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days3 2211. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)NONE10B. KIND OF BUSINESS OR  
INDUSTRY—

11. BIRTHPLACE (State or foreign country)

BALTIMORE12. CITIZEN OF  
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

HOWARD F. OSTERMANN

14. MOTHER'S MAIDEN NAME

VERNAL SKLINAR15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)NO16. SOCIAL  
SECURITY NO.NONE.

17. INFORMANT

ADDRESS

HOWARD F OSTERMANN 1707 E FEDERAL.

18.

7544

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Congenital Heart Disease  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH4 months

ANTECEDENT CAUSES

(B) —  
DUE TODISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(C) —OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-18, 1950, to 4-18, 1950, that I last saw the  
deceased alive on 4-18, 1950, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Judith B. Taudan

M. D.

23B. ADDRESS

Sinai Hospital Baltimore

23C. DATE SIGNED

4-18-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)BURIAL

24B. DATE

APRIL 20-50

24C. NAME OF CEMETERY OR CREMATORY

MORELAND PARK CEM.

24D. LOCATION (City, town, or county)

TAYLOR AVE

(State)

MD.DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams

25. FUNERAL DIRECTOR

ADDRESS

2011 Belair Rd. 7110 BELAIR RD.

APR 19 1950

157E

STATE OF TEXAS

COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Texas

My commission expires this day of \_\_\_\_\_, 19\_\_.

WITNESSES my hand and seal of office this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Texas

My commission expires this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Texas

My commission expires this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Texas

My commission expires this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Texas

My commission expires this day of \_\_\_\_\_, 19\_\_.

Notary Public in and for the State of Texas

My commission expires this day of \_\_\_\_\_, 19\_\_.

H-200

50 3644

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3644

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>John S. Houck</i>			2. DATE OF DEATH <i>Apr. 17<sup>th</sup> 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2873 Brandon Ave.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>80</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> <i>8-02</i>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>1835 W. Chester St.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Feb. 28<sup>th</sup> 1896</i>	9. AGE (In years: last birthday) <i>74</i>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Constable (Retired)</i>			11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>People's Court</i>			12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME <i>Henry Houck</i>			14. MOTHER'S MAIDEN NAME <i>Mary Kelly</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <i>Wife Catherine Johnson - 2873 Brandon Ave.</i>			ADDRESS _____		

18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>Senility</i> DUE TO _____	INTERVAL BETWEEN ONSET AND DEATH <i>yes.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Hypertensive Cardio-Vascular</i> DUE TO _____	<i>yes.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <i>arteriosclerotic heart disease</i> DUE TO _____	

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION <i>1</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Feb 15, 1950</i> to <i>April 17, 1950</i> , that I last saw the deceased alive on <i>4-17</i> , 1950, and that death occurred at <i>10 P.M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>William G. Fearis</i>	23B. ADDRESS <i>3025 Belair Road</i>	23C. DATE SIGNED <i>4-18-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4/20/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		

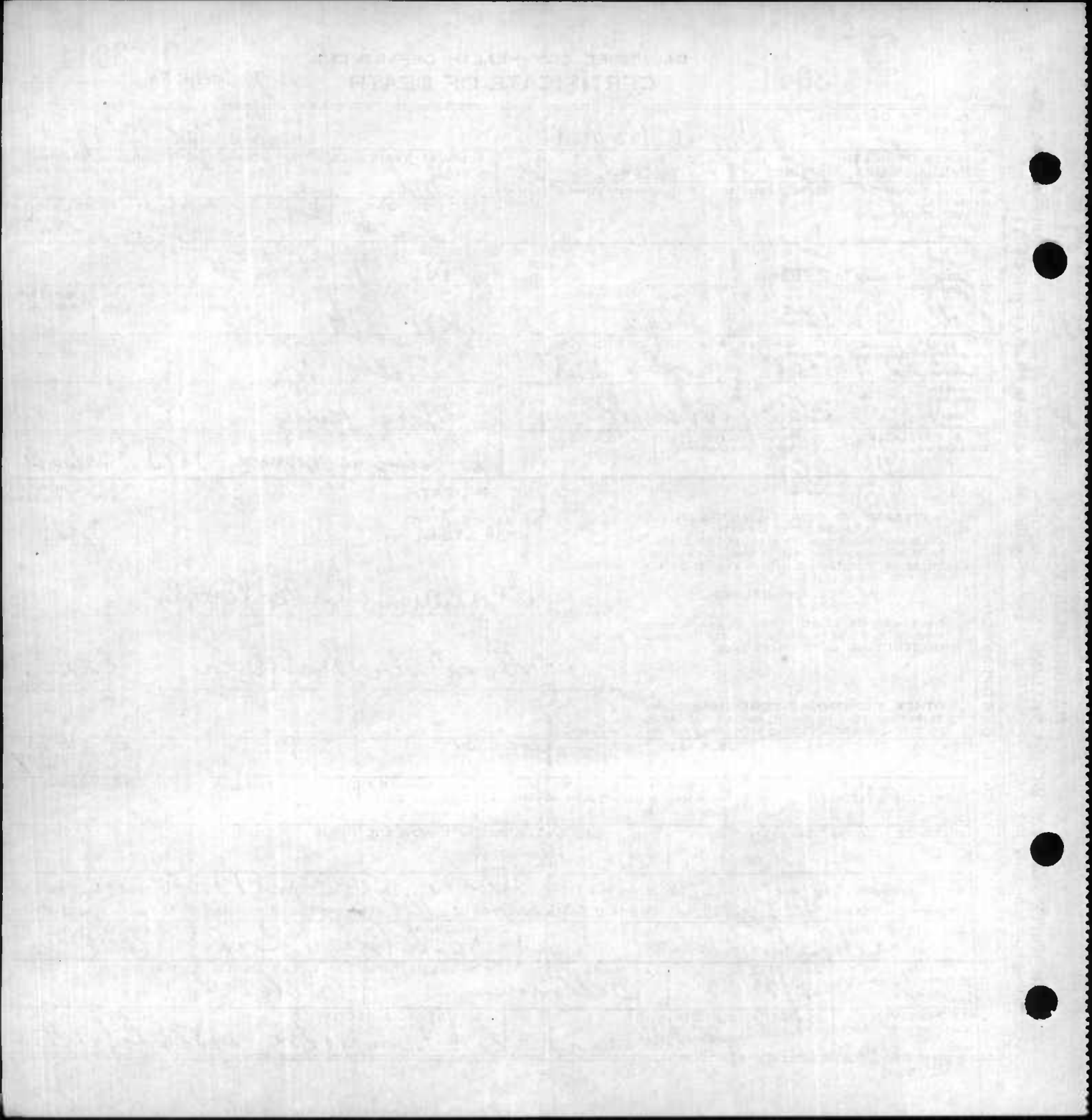
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 19 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>E. J. Ganning, Inc.</i>	ADDRESS <i>19386 Lafayette Ave.</i>
--	---	--	--

61098

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7-520

50 3645

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3645

Registered No. ....

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sophie Janiewski

2. DATE  
OF  
DEATH

Apr. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

6-22-86

9. AGE (In years last birthday)

63

10. Under 1 Year 11. Under 24 Hours

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 443X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Cerebral embolism

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8, 1950 to 4/18, 1950, that I last saw the deceased alive on 4/18, 1950, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Walter L. Green

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/18/50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 19 1950

Christington Williams, M.D.

Fred Wozniakowski

1930 Eastern Ave 931

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of burial place		17. Signature of interment		18. Signature of burial	
19. Signature of burial		20. Signature of burial		21. Signature of burial	
22. Signature of burial		23. Signature of burial		24. Signature of burial	
25. Signature of burial		26. Signature of burial		27. Signature of burial	
28. Signature of burial		29. Signature of burial		30. Signature of burial	
31. Signature of burial		32. Signature of burial		33. Signature of burial	
34. Signature of burial		35. Signature of burial		36. Signature of burial	
37. Signature of burial		38. Signature of burial		39. Signature of burial	
40. Signature of burial		41. Signature of burial		42. Signature of burial	
43. Signature of burial		44. Signature of burial		45. Signature of burial	
46. Signature of burial		47. Signature of burial		48. Signature of burial	
49. Signature of burial		50. Signature of burial		51. Signature of burial	
52. Signature of burial		53. Signature of burial		54. Signature of burial	
55. Signature of burial		56. Signature of burial		57. Signature of burial	
58. Signature of burial		59. Signature of burial		60. Signature of burial	
61. Signature of burial		62. Signature of burial		63. Signature of burial	
64. Signature of burial		65. Signature of burial		66. Signature of burial	
67. Signature of burial		68. Signature of burial		69. Signature of burial	
70. Signature of burial		71. Signature of burial		72. Signature of burial	
73. Signature of burial		74. Signature of burial		75. Signature of burial	
76. Signature of burial		77. Signature of burial		78. Signature of burial	
79. Signature of burial		80. Signature of burial		81. Signature of burial	
82. Signature of burial		83. Signature of burial		84. Signature of burial	
85. Signature of burial		86. Signature of burial		87. Signature of burial	
88. Signature of burial		89. Signature of burial		90. Signature of burial	
91. Signature of burial		92. Signature of burial		93. Signature of burial	
94. Signature of burial		95. Signature of burial		96. Signature of burial	
97. Signature of burial		98. Signature of burial		99. Signature of burial	
100. Signature of burial		101. Signature of burial		102. Signature of burial	



BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3646  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Mrs. Edna Celeste Bull</b>			2. DATE OF DEATH <b>April 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>836 Wellington Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>13-06</b>		
c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>836 Wellington Street</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>August 8, 1886</b>	9. AGE (In years last birthday) <b>63</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
13. FATHER'S NAME <b>Charles R. Hobbs</b>			14. MOTHER'S MAIDEN NAME <b>Frances Myers</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>---</b>		
17. INFORMANT <b>Mrs. Ruth F. Craig</b>			ADDRESS <b>836 Wellington Street</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Artery Dis</b> DUE TO <b>---</b> DUE TO <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 Days</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Apr. 18, 1950</b> to <b>Apr. 18, 1950</b> that I last saw the deceased alive on <b>Apr. 18, 1950</b> and that death occurred at <b>2:30 P. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Edward H. Hossman, M.D.</b>		23B. ADDRESS <b>4027 Falls Rd.</b>		23C. DATE SIGNED <b>4/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 21, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 19 1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>	
VS 150				ADDRESS <b>3631 Falls Road</b>	

CERTIFICATE OF DEATH

April 1, 1917

Line, John Oliver, Jr.

Married

California

310 North 1st Street

San Francisco, Cal.

Male

August 2, 1868

White

Single

U.S.A.

Married

at home

Thomas, Mary

Charles E. Thomas

San Francisco, Cal.

Coroner's Certificate  
No. 1000

April 1, 1917  
John Oliver, Jr.  
310 North 1st Street

April 1, 1917

San Francisco, Cal.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3647  
Registered No.

BIRTH NO.

50 3647

1. NAME OF DECEASED  
(Type or Print)

Mrs. Olivia Anna Baublitz

2. DATE  
OF  
DEATH

April 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

3826 Hickory Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

13-07

D. STREET ADDRESS (If rural, give location)

3826 Hickory Avenue

c. Length of stay in Baltimore

20 years

Yrs.  
Mos.  
Days

5. SEX

Female

White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

February 21, 1870

9. AGE (In years

last birthday)

80

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

John S. Bayne

14. MOTHER'S MAIDEN NAME

Sarah E. -----

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

---

17. INFORMANT

ADDRESS

Mrs. David Cramer 3826 Hickory Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic C.V.P.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

+ decompensation -

2 weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Generalized arteriosclerosis

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1940, to April 17, 1950, that I last saw the deceased alive on 4-17, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

April 20, 1950

St. Mary's (Hampden)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burgee Funeral Home

3631 Falls Road

APR 19 1950

937

STATE OF NEW YORK

IN SENATE

January 11, 1910

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1899

AND

CONFIRMED BY THE SENATE

ALBANY

1910

PRINTED BY THE SENATE

JOHN P. HENNING

PRINTED BY THE SENATE

NEW YORK: J. B. LIPPINCOTT & CO., 15 N. 2ND ST., 1910.

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NEW YORK: J. B. LIPPINCOTT & CO., 15 N. 2ND ST., 1910.

P-640

50 3648

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3648  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MRS. LUCY PURLEY</i>		2. DATE OF DEATH <i>15 April 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balls City</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Good Samaritan Hosp. 68 37 N. Carey St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 3-01</i>			
c. Length of stay in Baltimore <i>35 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>107 S. Bond St</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <i>9/19/1875</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>James City Co., Va</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Clement Tyler 9 S. Register St</i>	
18. <i>443X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(A) <i>Cerebral hemorrhage</i>			<i>2 days</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO <i>Hypertensive and arteriosclerotic cardiovascular disease.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>Diabetes mellitus</i>			
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>13 April, 1950</i> , to <i>15 April, 1950</i> , that I last saw the deceased alive on <i>15 April, 1950</i> , and that death occurred at <i>8:30 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Emile H. Henning</i>		23B. ADDRESS <i>M. D. 601 Wisconsin Way</i>		23C. DATE SIGNED <i>15 April 50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/21/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Brooklyn C. C. M.</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE <i>Timothy Williams</i>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <i>APR 19 1950</i>		24H. REGISTRAR'S SIGNATURE		24I. FUNERAL DIRECTOR'S ADDRESS <i>Elmer O. Wilson 1100 Brantley Ave</i>	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 3649**

BIRTH NO. **50 3649**

1. NAME OF DECEASED  
(Type or Print)

*Margaret S. Moser*

2. DATE  
OF  
DEATH

*April 18, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

*3125 Brendan Ave.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore,*

*26-03*

D. STREET ADDRESS (If rural, give location)

*3125 Brendan Ave.*

c. Length of stay in Baltimore

*life*

Yrs.  
Mos.  
Days

5. SEX

*female*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

*Widow*

8. DATE OF BIRTH

*Sept. 27, 1872*

9. AGE (in years - last birthday)

*72*

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired Saleslady*

10B. KIND OF BUSINESS OR INDUSTRY

*Department Store*

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*James Henderson,*

14. MOTHER'S MAIDEN NAME

*Mary Bennett*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

*no*

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*212-03-4169*

17. INFORMANT

ADDRESS

*Mr. George Hamilton, 3125 Brendan Ave.*

18.

*450.0*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

*Arteriosclerosis, Generalized*

(A)

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*10 years*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Malnutrition*

(C)

*None*

19A. DATE OF OPERATION

*None*

19B. MAJOR FINDINGS OF OPERATION

*None*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 1, 1950*, to *April 18, 1950*, that I last saw the deceased alive on *April 14, 1950*, and that death occurred at *5:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Thelma F. Cook*

23B. ADDRESS

*4200 Sheldon Avenue*

23C. DATE SIGNED

*April 18, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*burial*

24B. DATE

*Apr. 21, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Cathedral Cem.*

24D. LOCATION (City, town, or county)

*Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston Williams, Jr.*

25. FUNERAL DIRECTOR

ADDRESS

*Wm. J. Commons 4611 Park Heights Ave.*

APR 19 1950

29863

97



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3650  
Registered No.

BIRTH NO. 50 3650

1. NAME OF DECEASED  
(Type or Print)

FRANKLIN LUTHER MATTHIAS

2. DATE  
OF  
DEATH

April 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Pennsylvania

Adam

HOSPITAL OR

INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rural Littlestown

D. STREET ADDRESS (If rural, give location)

Littlestown R. D. #2

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Apr. 15, 1891

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Matthias

14. MOTHER'S MAIDEN NAME

Laura Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

--

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

J. W. Little &amp; Son- Littlestown, Pa.

18.

E974.x I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Strangulation by hanging

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Above hospital

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Johns Hopkins Hospital

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

4/19/50

8:00

A.M.

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☒  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

Strangled himself with the sash cord  
from the venetian blind22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Carl H. Boyer

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

4/19/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

4/20/50

24C. NAME OF CEMETERY OR CREMATORY

St. Mary's Union C em.

24D. LOCATION (City, town, or county)

Silver Run, Carroll Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Franklin Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

26 m. J. Pickens &amp; Sons Balto Md.

APR 19 1950

VS 151

N-991

000VV

164a



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3651

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Caroline Puppee

2. DATE  
OF  
DEATH

4/19/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Maryland Gen. Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-02

c. Length of stay in Baltimore

74 years

D. STREET ADDRESS (If rural, give location)

4245 Nicholas Ave.

5. SEX

Fe

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

March 27, 1876

9. AGE (In years last birthday)

74

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Hswf.

10B. KIND OF BUSINESS OR INDUSTRY

Hswf.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Roth

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Frank Puppee Proch Hall

18. 490X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar + Bronchial pneumonia

5 days

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obstructive jaundice  
Cerebral Vascular Accident  
Hypertensive Cardiovascular Disease

3 days

years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/16, 1950, to 4/19, 1950, that I last saw the deceased alive on 4/19, 1950, and that death occurred at 7:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 20 1950

Huntington Williams, M.D.

Edgar L Lane Church Hill Md





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Jacob Cummins

2. DATE  
OF  
DEATH

4-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4 N. Chapel St

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Mar. 18, 1880

9. AGE (In years  
last birthday)

70

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Sanitor.

10B. KIND OF BUSINESS OR

INDUSTRY  
Govt. Housing Project

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Cummins

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

219-10-1565

17. INFORMANT

B. C. H. Records, 4940 Eastern Ave.

ADDRESS

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)Hypertensive Arteriosclerotic cardiovascular  
Disease

(A)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20-48, 19 to April 17, 1950 that I last saw the  
deceased alive on April 17, 1950 and that death occurred at 6PM m., from the causes and on the date stated above.

23A. SIGNATURE

J. B. O'Brien

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-19-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

April 21, 1950 Pine Grove L.B. Cem.

Parkton, Balto. Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

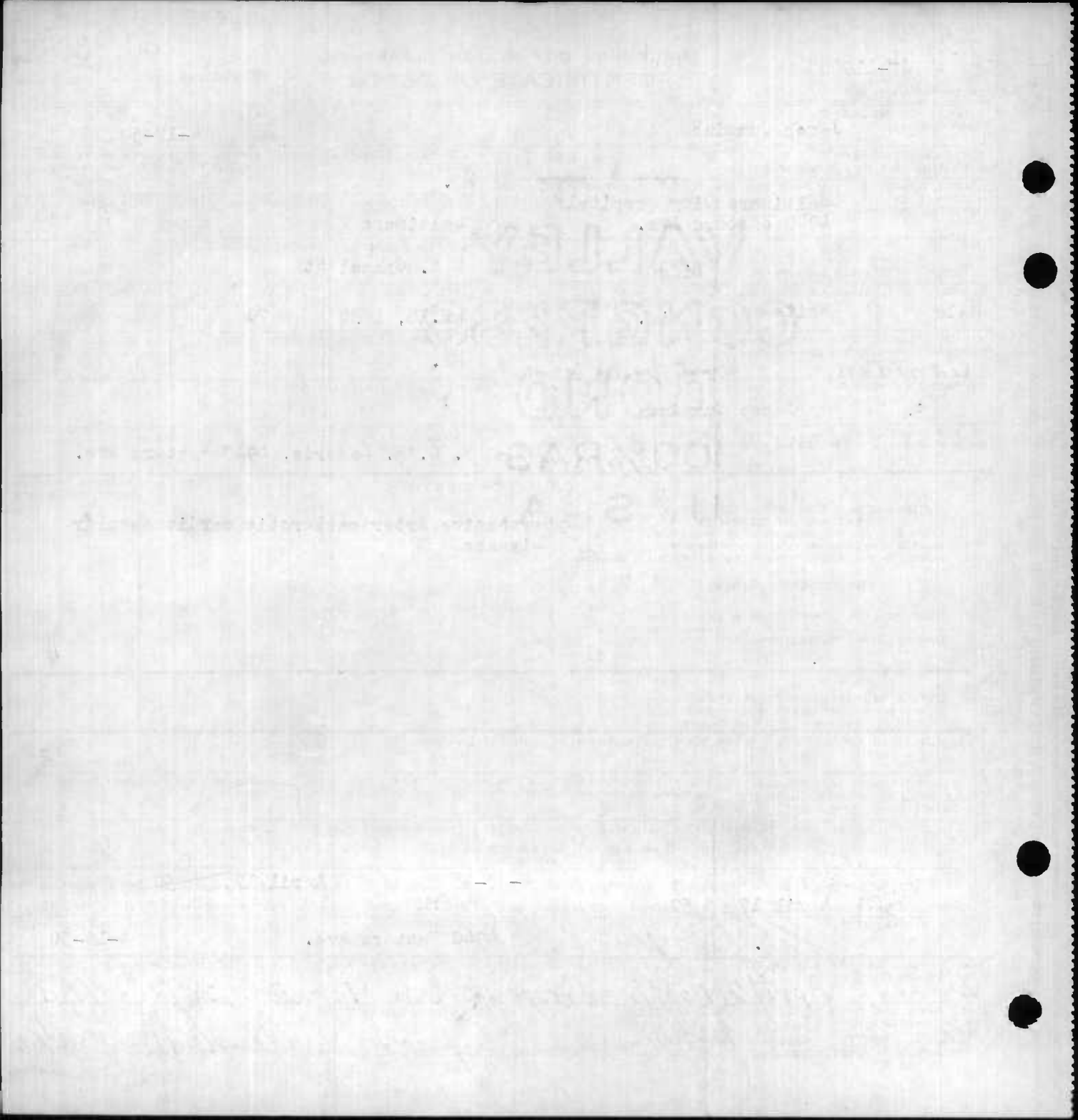
25. FUNERAL DIRECTOR

ADDRESS

APR 20 1950

Huntington Williams, M.D.

J. Jacob Harkenstein, New Freedom



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

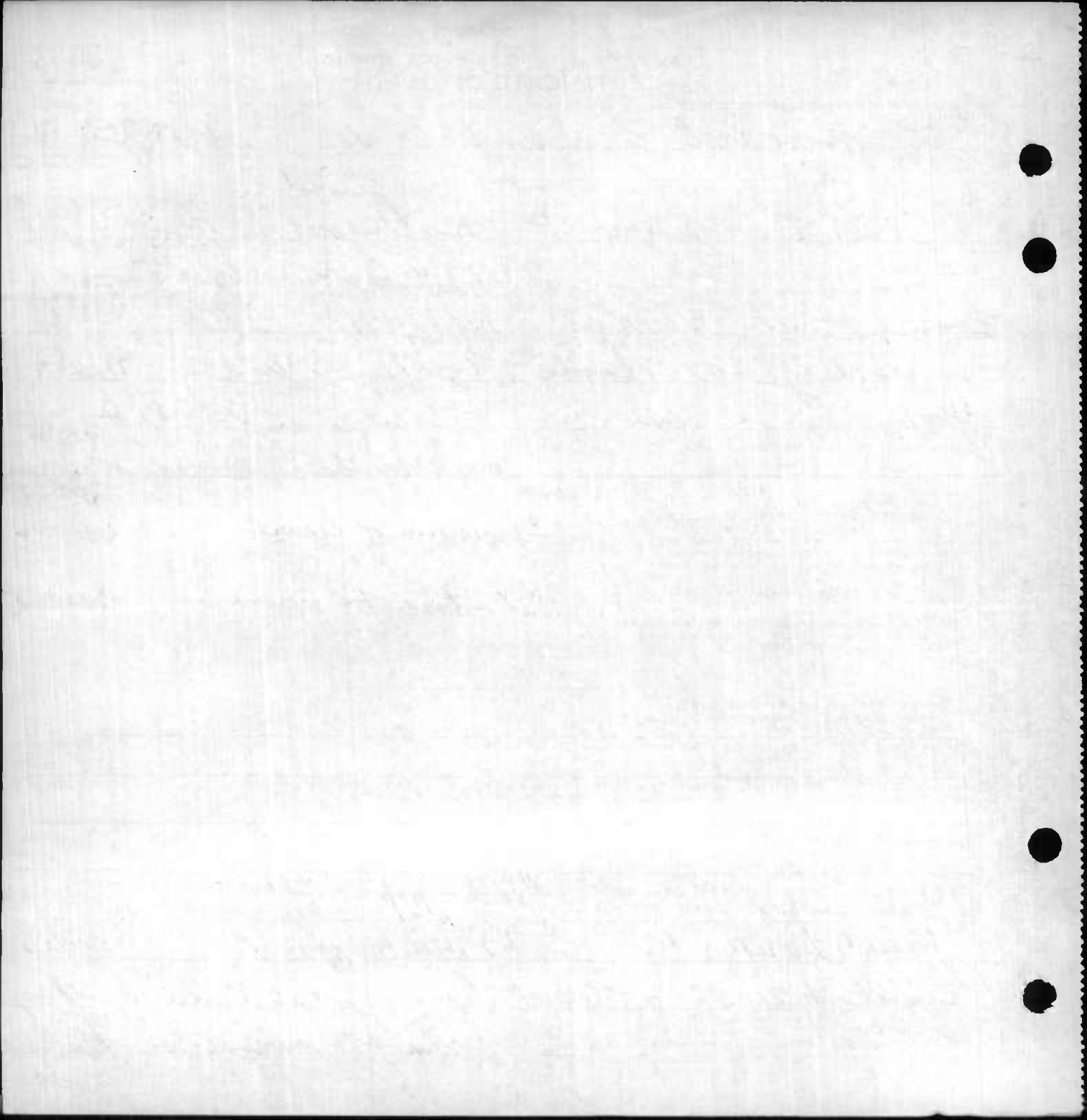
50 3653  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Margaret E. Sunderland</i>		2. DATE OF DEATH <i>4/18/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>824 Burgundy St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 21-01</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>824 Burgundy St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12/18/1918</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years; last birthday) <i>31</i>
13. FATHER'S NAME <i>John R. Lass</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>-</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
16. SOCIAL SECURITY NO. <i>-</i>		14. MOTHER'S MAIDEN NAME <i>Freda Scheller</i>	
17. INFORMANT <i>Mr Kern A. Sunderland</i>		ADDRESS <i>824 Burgundy St</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>171X Carcinoma of cervix</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>one week</i>
CAUSE OF DEATH (A) <i>Metastases to Brain</i> DUE TO		
ANTECEDENT CAUSES (B) _____ DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____ DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

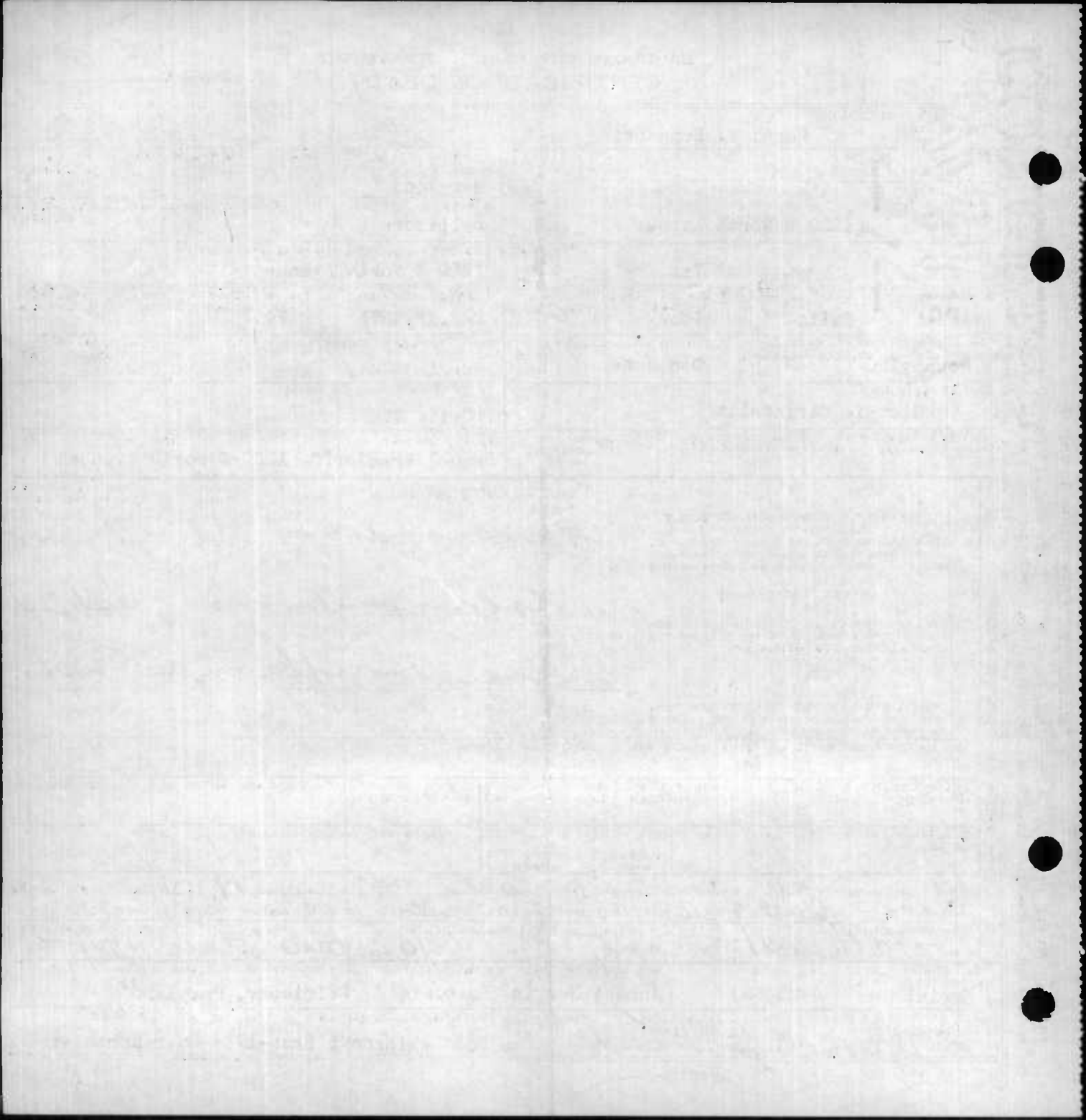
19A. DATE OF OPERATION <i>4/18/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/14/50</i> , to <i>4/18/50</i> , that I last saw the deceased alive on <i>4/18/50</i> , and that death occurred at <i>5 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph L. Lawkaitis</i>		23B. ADDRESS <i>6754 Washington Blvd</i>		23C. DATE SIGNED <i>4/19/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4/21/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>2930 Frederick Ave. Baltimore Md.</i>		
DATE RECEIVED BY <i>APR 20 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Williams</i>		25. FUNERAL DIRECTOR <i>John J. Howard Son</i>	
				ADDRESS <i>48a St.</i>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3654BIRTH NO. 50 3654

1. NAME OF DECEASED (Type or Print) <b>Sarah E. Brandorff</b>			2. DATE OF DEATH <b>April 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1220 W North Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>37 Yrs.</b>			O. STREET ADDRESS (If rural, give location) <b>1220 W North Avenue</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 15, 1875</b>		9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>Michale Rabinowitz</b>			14. MOTHER'S MAIDEN NAME <b>Celia ??</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Samuel Brandorff- 1220 W North Avenue</b> ✓		

18. <b>78TX, 422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocarditis</b> DUE TO		CAUSE OF DEATH <b>Myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>about 6 mos.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerosis</b> DUE TO		<b>Arteriosclerosis</b>		<b>Indefinite</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.		<b>Recent Influenza</b> DUE TO		<b>- 2 wks.</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June</b> , 19 <b>43</b> to <b>April 19</b> , 19 <b>50</b> that I last saw the deceased alive on <b>April 19, 1950</b> and that death occurred at <b>6:30 a. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Halhaull Shpitz</b> M. O.		23B. ADDRESS <b>1810 Eastaw Place</b>		23C. DATE SIGNED <b>4/19/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-20-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Anshei Nessin Rosedale</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Sol Levinson &amp; Bros-1124-26 " North Ave.</b>	





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3655

Registered No. \_\_\_\_\_

BIRTH NO. 50 3655

1. NAME OF DECEASED (Type or Print) <b>HELEN GIBSON</b> (Helen T. Gibson)			2. DATE OF DEATH <b>4/18/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>WEST BALTO. GEN HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>9-09</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>III6 E. Lanvale Street</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, <del>CARRIED</del> , WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 14, 1900</b>		9. AGE (In years, last birthday) <b>49</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Daniel T. Boyd</b>			14. MOTHER'S MAIDEN NAME <b>Bridget Morris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT ADDRESS <b>Mr. Howard F. Gibson - III6 E. Lanvale Street</b>		

MEDICAL CERTIFICATION	18. <b>340.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>PNEUMOCOCCAL MENINGITIS AND SEPTICEMIA</b> DUE TO (B) <b>BRONCHO PNEUMONIA</b> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH		
	19. <b>II</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>ANTECEDENT CAUSES</b> <b>CEREBROVASCULAR ACCIDENT</b>		
	19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>4/7/1950</b> , to <b>4/18/1950</b> that I last saw the deceased alive on <b>4/18/1950</b> , and that death occurred at <b>7:45 P</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>George J. Ruth</i>	23B. ADDRESS <b>W 3615</b>	23C. DATE SIGNED <b>4/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-21-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	24D. LOCATION (City, town, or county) (State) <b>Frederick Road, Balto: Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 20 1950</b>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR ADDRESS <b>George J. Ruth, Inc. - 1735 Harford Avenue</b> <i>George J. Ruth Inc.</i>	

CERTIFICATE OF DEATH

1912

John Gibson

John Gibson

John Gibson

John Gibson

John Gibson

John Gibson

John Gibson

John Gibson

John Gibson

John Gibson

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3656  
Registered No. \_\_\_\_\_

R-300  
50 3656  
BIRTH NO. \_\_\_\_\_

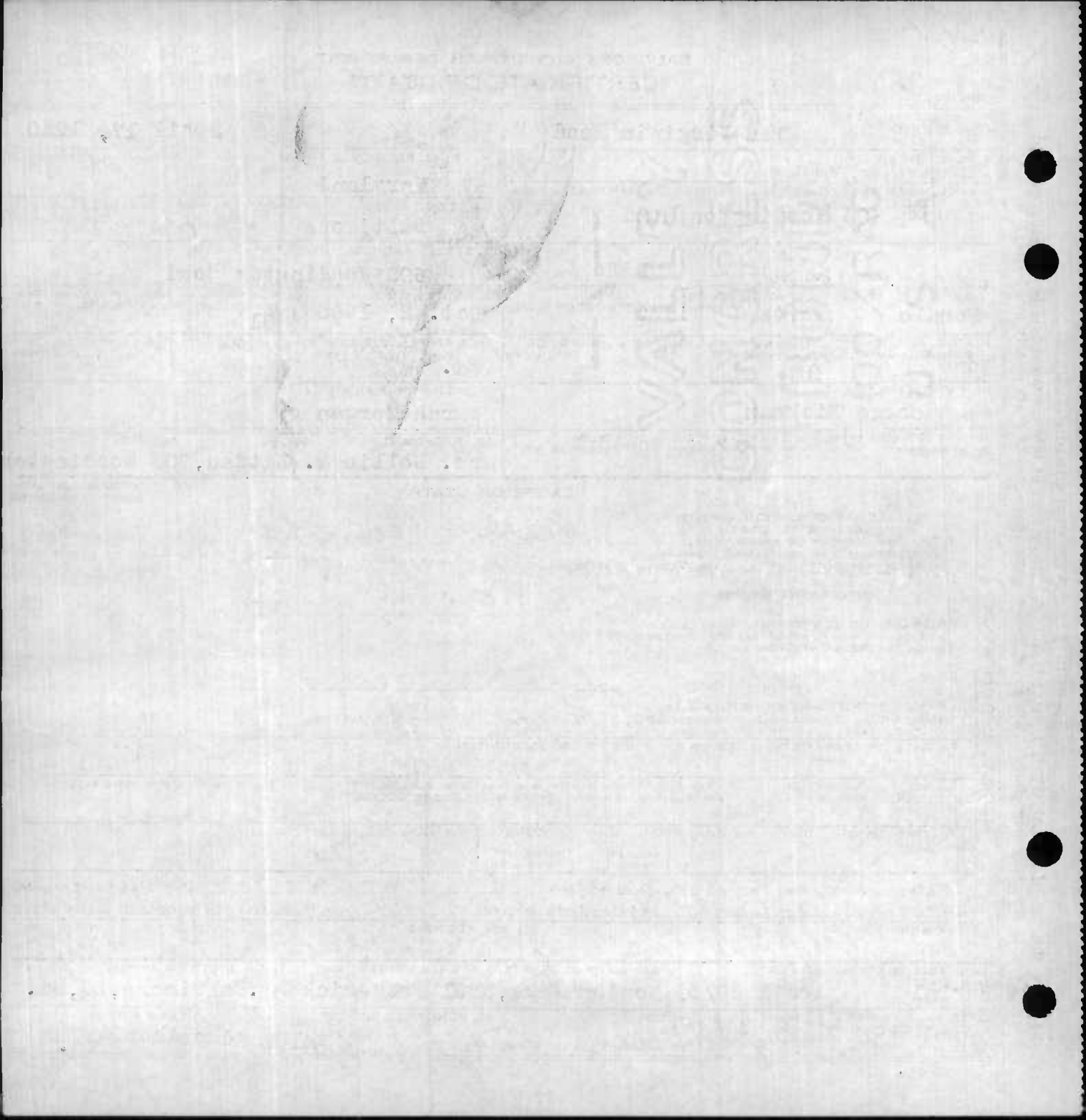
1. NAME OF DECEASED (Type or Print) <b>Ella Virginia Read</b>			2. DATE OF DEATH <b>April 17, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>603 Woodington Road</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 16-08</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>603 Woodington Road</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Oct. 2, 1868</b>		9. AGE (In years; last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Ma.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>George Hickman</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Morgan</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Nellie M. Litzau, 603 Woodington Rd.</b>		

<p>18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>Cerebral hemorrhage</b> DUE TO</p> <p>(B) <b>arterio sclerosis</b> DUE TO</p> <p>(C) <b>Hypertension</b></p>	<p>INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b></p>

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>1948</b> , 19____, to <b>4-17</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-17</b> , 19 <b>50</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. Williams</b>		23B. ADDRESS <b>3921 Edmondson Ave.</b>		23C. DATE SIGNED <b>4/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park, 3801 Frederick Rd.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, 29, Md.</b>	
LOCAL REGISTRAR'S SIGNATURE <b>Wm. Williams</b>		25. FUNERAL DIRECTOR ADDRESS <b>Harry A. Litzau, 4101 Edmondson Ave.</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Y-524

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3657

BIRTH NO. 50 3657

1. NAME OF DECEASED (Type or Print) <b>Howard D. Yingling</b>		2. DATE OF DEATH <b>April 17/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>20-08</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>349 Yale Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>349 Yale Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 25/80</b>
10A. USUAL OCCUPATION (Give kind of work depending on age of working life, even if retired) <b>Retired Butcher</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <b>69</b>
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Filmore Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ward</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220 05 3478</b>	
17. INFORMANT <b>Mrs. Lola Yingling, 349 Yale Ave.</b>		ADDRESS	

18. **442X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 yrs

5 yrs

?

19A. DATE OF OPERATION **0** 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Apr 1**, 19**50**, to **Apr. 17**, 19**50**, that I last saw the deceased alive on **Apr 16**, 19**50**, and that death occurred at **1<sup>00</sup> P. M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**Burial****April 20/50****Western****Edmondson Ave.****& Longwood St. Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**APR 20 1950****Huntington Williams, M.D.****Harry H. Witzke****101 Edmondson Ave.**

VS 150

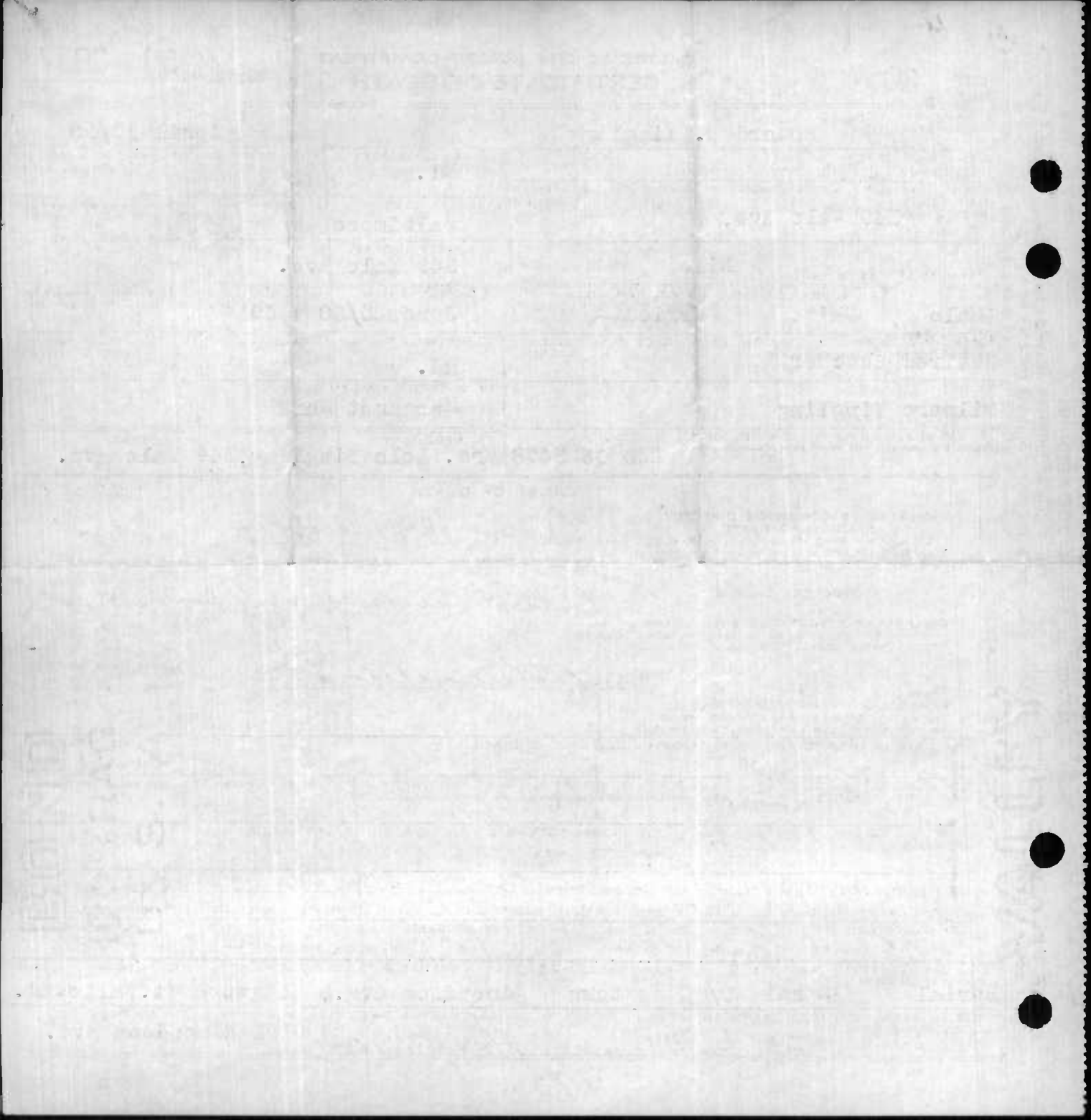
45261

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

416X 50 3658  
Registered No. 50-3658

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lillian Sharpe

2. DATE

OF DEATH April 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

60 1408 Orleans St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 5-01

D. STREET ADDRESS (If rural, give location)

1408 Orleans Street

C. Length of stay in Baltimore

sev. yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

39

If Under 1 Year Months: Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lewis Edwards

14. MOTHER'S MAIDEN NAME

Ella Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Jeremiah Sharpe-1408 Orleans St.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure

DUE TO

?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic heart disease

DUE TO

?

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-3-1950 to 4-15-1950 that I last saw the deceased alive on 4-3-1950 and that death occurred at 7:55 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-20-50

24C. NAME OF CEMETERY OR CREMATORY

Oakland Cem.

24D. LOCATION (City, town, or county)

Chuckatuck, Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

4-20-50

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Robert E. Williams-1515 McEldery St.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Virginia Cichocki

2. DATE  
OF  
DEATH

4-19-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2433 Fleet Street

c. Length of stay in Baltimore

Life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 26-1918

9. AGE (in years last birthday)

32

If Under 1 Year

If Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OPERATIVE

10B. KIND OF BUSINESS OR INDUSTRY

TIES (M)

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph W. Cichocki

14. MOTHER'S MAIDEN NAME

Catherine Kwiatkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

214-14-4482

17. INFORMANT

Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18.

002X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cor pulmonale

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary fibrosis

DUE TO

(C) Inactive pulmonary tuberculosis

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-14-1950 to 4-19-1950, that I last saw the deceased alive on 4-19-1950, and that death occurred at 6.55Am, from the causes and on the date stated above.

23A. SIGNATURE

J. J. Cogen

M. O.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-19-1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

April 22-1950

24C. NAME OF CEMETERY OR CREMATORY

St Stanislaus

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 20 1950

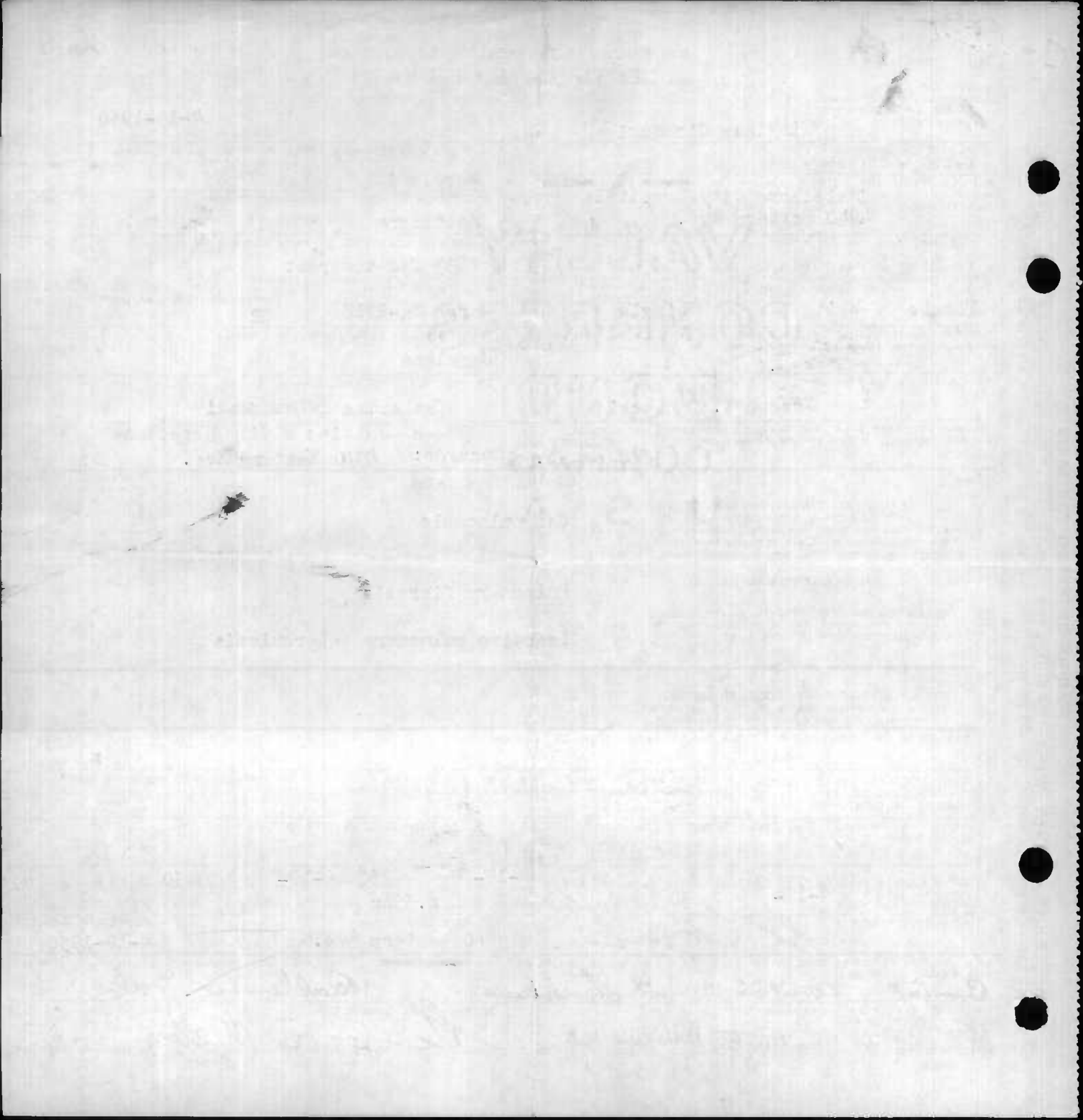
REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

George B. Weber

ADDRESS



M-620  
50 3660BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3660

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH ALICE MEYERS

2. DATE  
OF  
DEATH

April 19, 1950

3. PLACE OF DEATH:  
a. Baltimore City, Marylandb. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

5509 Park Heights Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
a. STATE  
b. COUNTY

Md.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

d. STREET ADDRESS (If rural, give location)

5509 Park Heights Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

June 15, 1886

9. AGE (In years;  
last birthday)

63

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William H. Carman

14. MOTHER'S MAIDEN NAME

Nellie Magers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. Eugenia Wegner 5509 Park Heights Ave

18.

602X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Calculi - both kidneys

INTERVAL BETWEEN  
ONSET AND DEATH

2/10/50

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 10, 1950, to April 19, 1950 that I last saw the deceased alive on April 19, 1950, and that death occurred at 4 A. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/22/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 20 1950

Huntington Williams, M.D.

Thos. J. Dickner &amp; Sons - Balt. Md.

VS 150

134a

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1000

DEPARTMENT OF THE ARMY

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B-400 129471  
50 3661

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3661  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>Clay Bell</b>	
2. DATE OF DEATH <b>April 17, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>2-02</b>	
D. STREET ADDRESS (If rural, give location) <b>18 S. Broadway</b>	
c. Length of stay in Baltimore <b>12 yrs.</b> Yrs. Mos. Days	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Nov. 29, 1908</b>	
9. AGE (In years last birthday) <b>41</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>	
10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>J. W. Rose</b>	
14. MOTHER'S MAIDEN NAME <b>Martha A. Ruble</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>32-22-4771</b>	
17. INFORMANT <b>Baltimore City Hospitals</b> <b>Records*4940 Eastern Ave.</b>	

18. <b>602X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary tuberculosis</b> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>6-7-</b> , 19 <b>49</b> , to <b>4-17-</b> , 19 <b>50</b> that I last saw the deceased alive on <b>4-17-</b> , 19 <b>50</b> , and that death occurred at <b>3:20P.</b> m., from the causes and on the date stated above.				
23A. SIGNATURE <b>J. L. Progen</b>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>4-18-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie Md</b>		25. FUNERAL DIRECTOR <b>W. H. [unclear]</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 20 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, Jr.</b>		ADDRESS <b>1214 S. Bond St</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

31014

13B



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3662

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NELSON

V.

ARBUTHNOT

2. DATE  
OF  
DEATH

April 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

2914 Hanover Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

township)

Baltimore

25-02A

D. STREET ADDRESS (If rural, give location)

2914 Hanover Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4/25/1895

9. AGE (In years

last birthday)

54

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Poultry &amp; Egg Store

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

George Arbuthnot

14. MOTHER'S MAIDEN NAME

Laura Forsythe

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Kerol Maicher ADDRESS  
Laura Finney Victory Road

18. E973.X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia due to self-administration  
of ether

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

2914 Hanover Street

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

April 18, 1950

? P m.

21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☒

21F. HOW DID INJURY OCCUR?

Self-administration of ether

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

4-19-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/22/50

24C. NAME OF CEMETERY OR CREMATORY

St. Marys-Namptden

24D. LOCATION (City, town, or county)

Balt. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 20 1950

Huntington Williams, M.D.

Wm. G. Dine, 1217 St. Paul St.

VS 151

N-974.0

15661

163X

✓

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Signature of physician		8. Signature of registrar	
9. Name of informant		10. Address of informant		11. Signature of informant		12. Signature of registrar	
13. Name of informant		14. Address of informant		15. Signature of informant		16. Signature of registrar	
17. Name of informant		18. Address of informant		19. Signature of informant		20. Signature of registrar	
21. Name of informant		22. Address of informant		23. Signature of informant		24. Signature of registrar	
25. Name of informant		26. Address of informant		27. Signature of informant		28. Signature of registrar	
29. Name of informant		30. Address of informant		31. Signature of informant		32. Signature of registrar	
33. Name of informant		34. Address of informant		35. Signature of informant		36. Signature of registrar	
37. Name of informant		38. Address of informant		39. Signature of informant		40. Signature of registrar	
41. Name of informant		42. Address of informant		43. Signature of informant		44. Signature of registrar	
45. Name of informant		46. Address of informant		47. Signature of informant		48. Signature of registrar	
49. Name of informant		50. Address of informant		51. Signature of informant		52. Signature of registrar	
53. Name of informant		54. Address of informant		55. Signature of informant		56. Signature of registrar	
57. Name of informant		58. Address of informant		59. Signature of informant		60. Signature of registrar	
61. Name of informant		62. Address of informant		63. Signature of informant		64. Signature of registrar	
65. Name of informant		66. Address of informant		67. Signature of informant		68. Signature of registrar	
69. Name of informant		70. Address of informant		71. Signature of informant		72. Signature of registrar	
73. Name of informant		74. Address of informant		75. Signature of informant		76. Signature of registrar	
77. Name of informant		78. Address of informant		79. Signature of informant		80. Signature of registrar	
81. Name of informant		82. Address of informant		83. Signature of informant		84. Signature of registrar	
85. Name of informant		86. Address of informant		87. Signature of informant		88. Signature of registrar	
89. Name of informant		90. Address of informant		91. Signature of informant		92. Signature of registrar	
93. Name of informant		94. Address of informant		95. Signature of informant		96. Signature of registrar	
97. Name of informant		98. Address of informant		99. Signature of informant		100. Signature of registrar	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3663BIRTH NO. 3663

1. NAME OF DECEASED (Type or Print) <b>PAUL I. TAYLOR</b>			2. DATE OF DEATH <b>April 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>15-07B</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2323 Rosedale Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2/24/1887</b>	9. AGE (In years last birthday) <b>63 (M.F.)</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Eutaw Savings Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Cadmus C. Taylor</b>			14. MOTHER'S MAIDEN NAME <b>Lillie Disharoon</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W.1</b>		16. SOCIAL SECURITY NO. <b>212-05-9113</b>			
17. INFORMANT <b>Mrs. Neva R. Taylor</b>			ADDRESS <b>2323 N. Rosedale</b>		

18. **420.1**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

(A) **Coronary artery disease with former occlusion and myocardial infarction**  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)   
DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

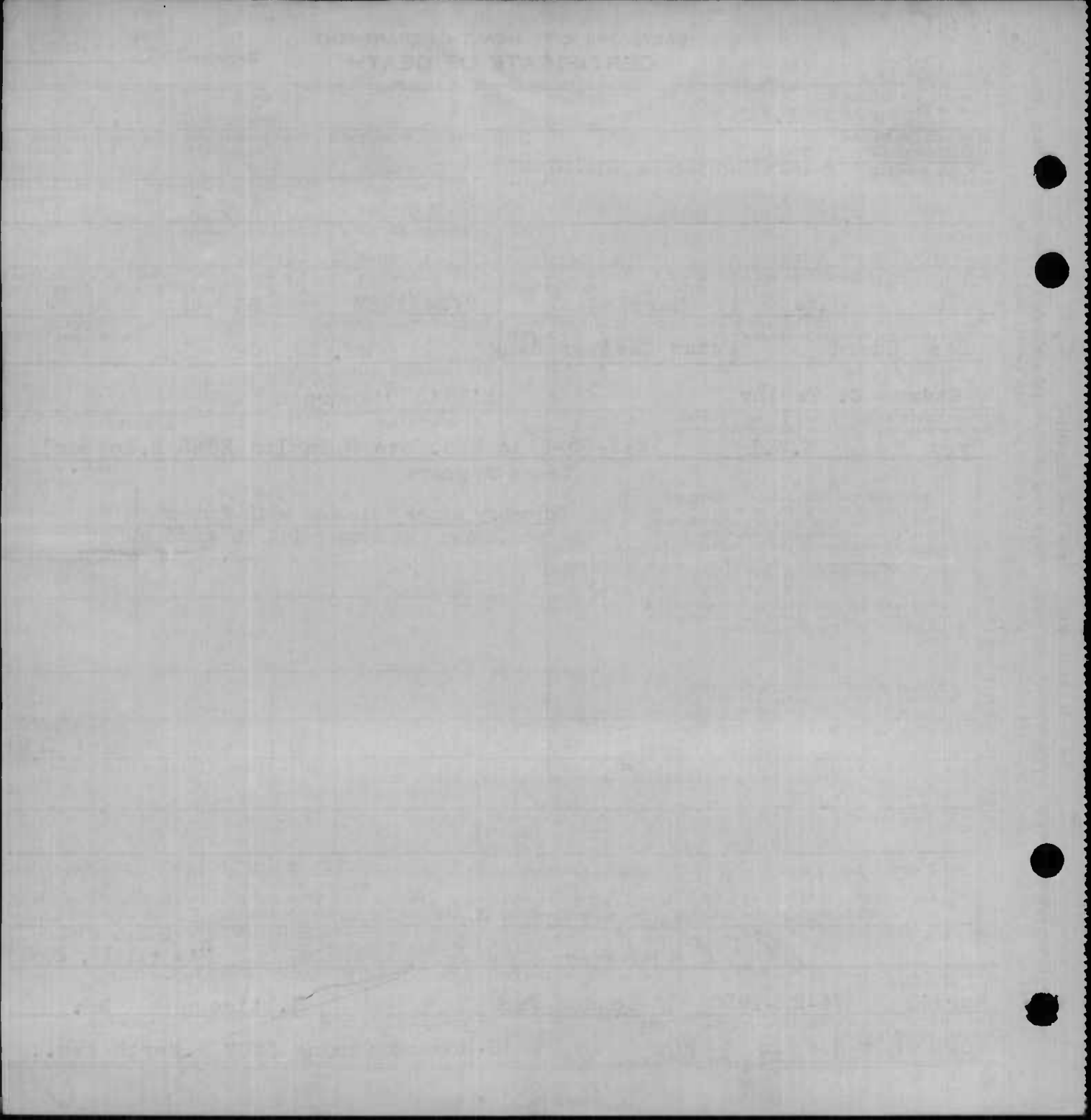
(C)   
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>RS Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>April 19, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-22-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>		25. FUNERAL DIRECTOR <b>G. Howard Strong 3207 W. North Ave.,</b>			





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3664

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eunice Shanks

2. DATE  
OF

DEATH April 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

5. FULL NAME OF

(If not in hospital or institution, give street address or

HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

location)

4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1536 McElderry St. Zone 5

c. Length of stay in Baltimore

life

5. SEX

Female

6. COLOR OR RACE  
Negro7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 6, 1931

9. AGE (In years

last birthday)

18

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

Private Family

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Arthur Lee Shanks

14. MOTHER'S MAIDEN NAME

Bernice Peace

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records\* 4940 Eastern Ave.

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Sudden death with convulsion during pneumothorax

19A. DATE OF OPERATION

3-14-50

19B. MAJOR FINDINGS OF OPERATION

Pneumonolysis--Pul. TBC with pneumothorax--left

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-22-1949, to 4-18-1950, that I last saw the  
deceased alive on 4-18-1950, and that death occurred at 10:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. J. Hogan

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-19-50

24A. BURIAL, CREMA-  
TION REMOVAL (Specify)

24B. DATE

4-22-50

24C. NAME OF CEMETERY OR CREMATORY

mf Calvary Cmc.

24D. LOCATION (City, town, or county)

Brooklyn ny

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Elroy O. Wilson 1000 B Street NW

ADDRESS

APR 20 1950



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3665BIRTH NO. 50 3665

1. NAME OF DECEASED (Type or Print) <b>RAYMOND HASKIN</b>			2. DATE OF DEATH <b>April 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Off Pier #6 Pratt St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Dundalk</b>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>226 Patapsco Avenue</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 10, 1923</b>	9. AGE (In years last birthday) <b>27</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sparrows Point</b>	11. BIRTHPLACE (State or foreign country) <b>Newberry, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Michael Haskin</b>			14. MOTHER'S MAIDEN NAME <b>Minnie Williams</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>232-30-9424</b>	17. INFORMANT ADDRESS <b>Mrs. Pear Moore, 14 Warring Rd. (Essex)</b>		

18. <b>E 929.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Drowning (Body found in water)</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C)</b>		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Harbor</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Pier 6 - Pratt Street</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>4/19/50 11:00 A.M.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Last seen 4/18/50 <b>Found drowned</b>

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE <b>RS Fisher</b>	23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>4/20/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-22-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Morganton U.E.</b>
24D. LOCATION (City, town, or county) (State) <b>Morganton U.E.</b>	24E. FUNERAL DIRECTOR <b>Frank Della Loe</b>	24F. ADDRESS <b>312 S. High St</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 20 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	

1911

OFFICE OF THE SECRETARY

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PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3666  
Registered No.

BIRTH NO. 50-07863

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Amos

2. DATE  
OF  
DEATH

Apr. 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write R.R. and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days  
11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Bonsal Amos

14. MOTHER'S MAIDEN NAME

Katherine?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

760.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Intrauterine Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Prematurity

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 1950, to 4/13, 1950, that I last saw the deceased alive on 4/13, 1950, and that death occurred at 7:05 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. J. Robinson, M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 20 1950

Huntington Williams, M.D.

Hospital Disposal

3667

160a

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

1. NAME OF LAND ACQUISITION PROJECT		2. DATE OF ACQUISITION	
3. NAME OF ACQUISITION AGENT		4. NAME OF ACQUISITION OFFICE	
5. NAME OF ACQUISITION OFFICE		6. NAME OF ACQUISITION OFFICE	
7. NAME OF ACQUISITION OFFICE		8. NAME OF ACQUISITION OFFICE	
9. NAME OF ACQUISITION OFFICE		10. NAME OF ACQUISITION OFFICE	
11. NAME OF ACQUISITION OFFICE		12. NAME OF ACQUISITION OFFICE	
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97. NAME OF ACQUISITION OFFICE		98. NAME OF ACQUISITION OFFICE	
99. NAME OF ACQUISITION OFFICE		100. NAME OF ACQUISITION OFFICE	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C-155 JL 137331  
50 3667  
BIRTH NO. 50-07674

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3667

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Chaffman- Mary Elizabeth</b>		2. DATE OF DEATH <b>4-16-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>Middleburg</b>	
c. Length of stay in Baltimore <b>Life</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>Rt. 21, Box 38, Middleburg, Balto., Co. Md</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>4-15-50</b>
9. AGE (In years last birthday)		10. Under 1 Year Months: Days: <b>1</b>	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balt, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Chaffman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave.</b>		ADDRESS	
18. <b>76r. 5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Congenital atelectasis</b> DUE TO <b>(B) Prematurity</b> DUE TO <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-15-50</b> , 19 <b>50</b> , to <b>April 16</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>April 16</b> , 19 <b>50</b> , and that death occurred at <b>6.30 PM</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>[Signature]</b> M. D.		23B. ADDRESS <b>4940 Eastern Ave.</b>	
23C. DATE SIGNED <b>4-17-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>	24B. DATE <b>4-18-50 @ 9:00 AM</b>	24C. NAME OF CEMETERY OR CREMATORY <b>B. C. H. Crematory</b>	24D. LOCATION (City, town, or county) (State) <b>4940 Eastern Ave.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 20 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>	
25. FUNERAL DIRECTOR		ADDRESS	

CERTIFICATE OF DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3668  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Amelia Limpert

2. DATE  
OF  
DEATH

April 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 427 N. Lakewood Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY \_\_\_\_\_

\_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

427 N. Lakewood Ave.

c. Length of stay in Baltimore Lifetime

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 8, 1866

9. AGE (In years last birthday)

84

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Peter Lattimore

14. MOTHER'S MAIDEN NAME

Fredericke Buddemeier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret Eichner 435 N. Lakewood

18.

163X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebrana lung

INTERVAL BETWEEN ONSET AND DEATH

1 yr

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from april 17, 1950, to april 17, 1950, that I last saw the deceased alive on april 17, 1950, and that death occurred at 9 p.m., from the causes and on the date stated above.

23A. SIGNATURE

July J. Shingay

M.D.

23B. ADDRESS

2700 Harford Road

23C. DATE SIGNED

april 18 1950

24A. BURIAL, REMOTION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 20, 1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 20 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2008 Orleans St.,

RECORDS OF THE  
CITY OF NEW YORK

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3669  
Registered No.

BIRTH NO. 35000

1. NAME OF DECEASED (Type or Print)		John E. Brown		2. DATE OF DEATH April 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. LENGTH OF STAY IN BALTIMORE 50 yrs.				D. STREET ADDRESS (If rural, give location) 924 N. Stricker St.	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 1882	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Cook - COLLEGE		11. BIRTHPLACE (State or foreign country) St. Marys Co. Md.	
13. FATHER'S NAME See Brown		14. MOTHER'S MAIDEN NAME Julian		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 216-05-6806		17. INFORMANT Leola Brown	
				ADDRESS 924 Stricker St.	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Myocardial insufficiency		DUE TO arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R S Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED April 18, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/22/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) A A Co. Md.		24E. FUNERAL DIRECTOR Metropolitan Funeral Home Inc.		24F. ADDRESS 924 N. Stricker St.	
DATE RECEIVED BY LOCAL REGISTRAR APR 20 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc.	





E 235

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3670  
Registered No.

50 3670  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Pearl M. Easton</i>			2. DATE OF DEATH <i>April 17 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1245 Union Ave.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 13-08</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1245 Union Ave</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 29 1889</i>		9. AGE (In years, last birthday) <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>?</i>
13. FATHER'S NAME <i>?</i>			14. MOTHER'S MAIDEN NAME <i>?</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>	17. INFORMANT ADDRESS <i>Albert R. Easton 1245 Union Ave</i>		

18. <i>443X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive C.V.D.</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>6</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>2-17</i> , 19 <i>43</i> , to <i>4-17</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>4-17</i> , 19 <i>50</i> , and that death occurred at <i>10 P</i> m., from the causes and on the date stated above.				
23A. SIGNATURE <i>Lawrence J. Hamauch</i>	23B. ADDRESS <i>3711 Jolly Rd</i>	23C. DATE SIGNED <i>4-19-50</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>April 20, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>	24D. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 20 1950</i>	REGISTRAR'S SIGNATURE <i>William W. Williams</i>	25. FUNERAL DIRECTOR ADDRESS <i>Paul E. Chenoweth 3615-17 Chestnut Ave</i>		

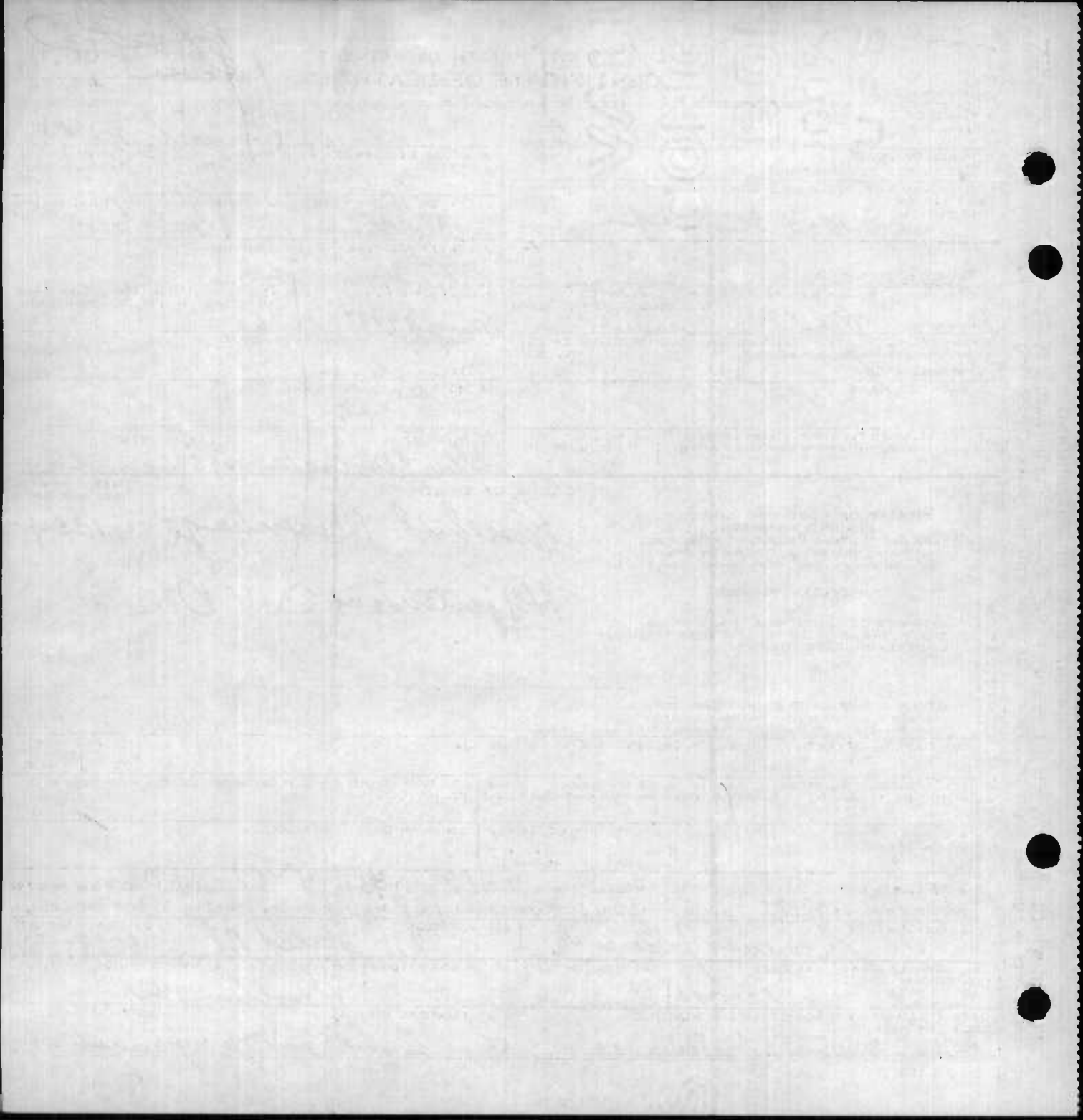
VS 150

3670

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

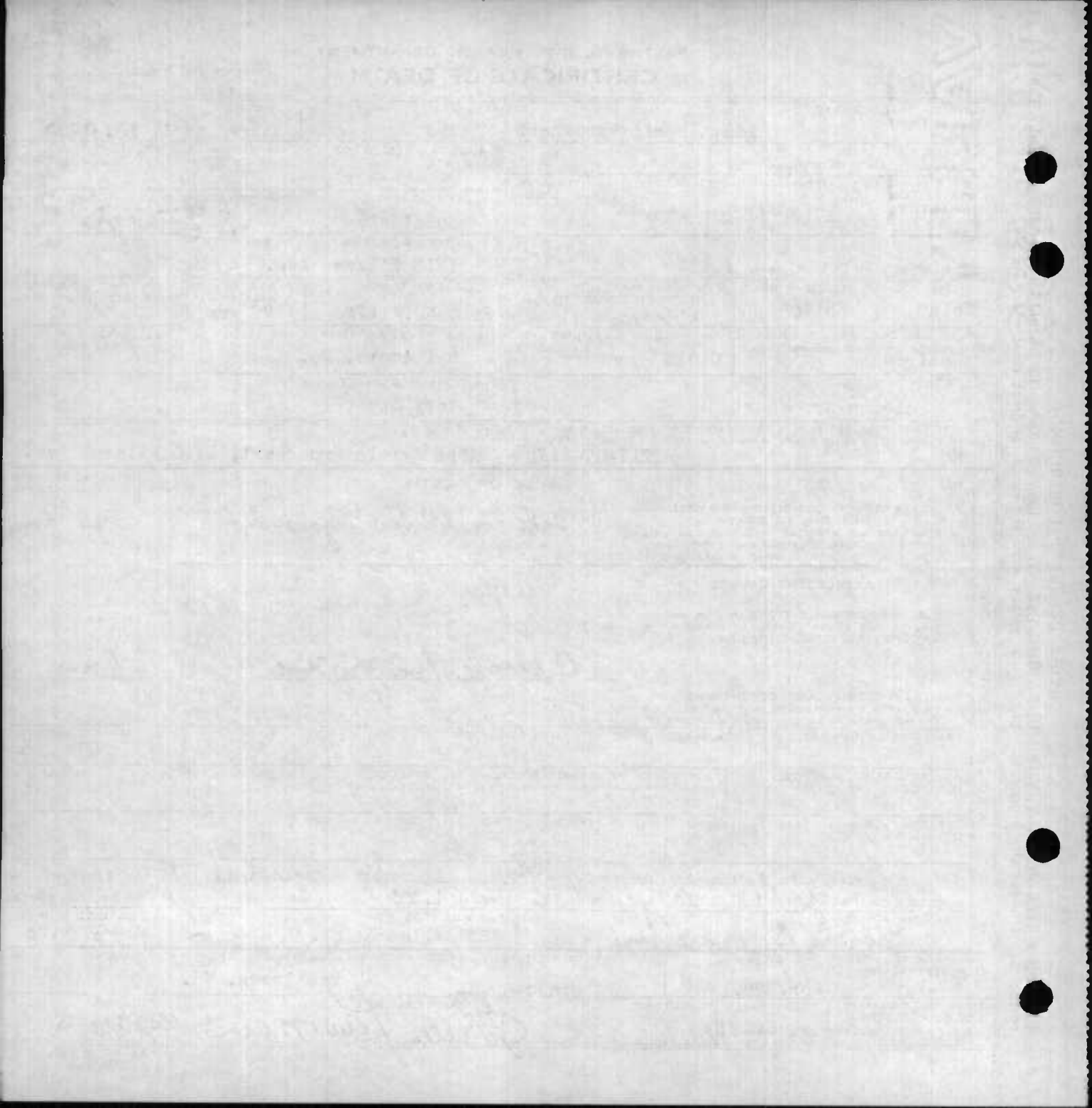
50 3671

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Adam Rheric Brookhart</b>			2. DATE OF DEATH <b>April 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1710 Wilkens Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>1710 Wilkens Ave.</b>			E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Feb. 20, 1872</b>	9. AGE (In years last birthday) <b>78 yrs</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Cloth Sponger</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? _____		
13. FATHER'S NAME <b>Solomon Brookhart</b>			14. MOTHER'S MAIDEN NAME <b>Mary Gross</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-07-1172</b>		
17. INFORMANT <b>Miss Myrtle Brookhart, 1710 Wilkens Ave.</b>			ADDRESS _____		

18. <b>472.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>arteriosclerotic Myocarditis</b> (A) _____ DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs. 4 mos.</b>		
ANTECEDENT CAUSES (B) _____ DUE TO _____ <b>age</b>			_____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <b>Arteriosclerotic gangrene of foot</b> _____			_____		
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			_____		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan</b> , 19 <b>49</b> , to <b>April 19, 1950</b> , that I last saw the deceased alive on <b>April 18, 1950</b> , and that death occurred at <b>1.40A m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Morris B. Schreiber</b> M. D.			23B. ADDRESS <b>3506 Ellamont St.</b>		23C. DATE SIGNED <b>4-20-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 22, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>Thelma L. Moore</b> ADDRESS <b>4510 Liberty Heights Ave.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 20 1950</b>		REGISTRAR'S SIGNATURE <b>W. H. Williams, Jr.</b>			



F621-131255  
50 3672

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3672  
Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>Marie Frisby</b>			2. DATE OF DEATH <b>4-19-1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>					
c. Length of stay in Baltimore <b>10yrs</b>			D. STREET ADDRESS (If rural, give location) <b>412 E. Oliver Street</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 24-1919</b>		9. AGE (In years last birthday) <b>30yrs</b>		10. Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WAITRESS</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>RESTURANT</b>			11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>William Hall</b>			14. MOTHER'S MAIDEN NAME <b>Ethel Dandridge</b>			15. INFORMATION (State or foreign country) <b>Baltimore City Hospitals</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>16-14-7320</b>			17. RECORDS: <b>4940 Eastern Ave.</b>		

18. <b>002 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) Congestive heart failure</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C) Pneumonectomy</b>					
19A. DATE OF OPERATION <b>April 18-1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Pulmonary Tuberculosis-Right Lung</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>8-22-</b> , 19 <b>49</b> , to <b>4-19-</b> , 1950, that I last saw the deceased alive on <b>4-19-</b> , 1950, and that death occurred at <b>7.13AM</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>J. J. [Signature]</b>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>4-19-1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/24/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mount Lown</b>	
24D. LOCATION (City, town, or county) (State) <b>PHILADELPHIA, PA.</b>		25. FUNERAL DIRECTOR <b>Charles R. Law</b> <b>THE CHARLES R. LAW MORTUARY</b>			

VS 150

78071

802-04 MADISON AVENUE 13B

BALTIMORE, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Funeral Home

Signature of Burial Society

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial



J 552 50 3673

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

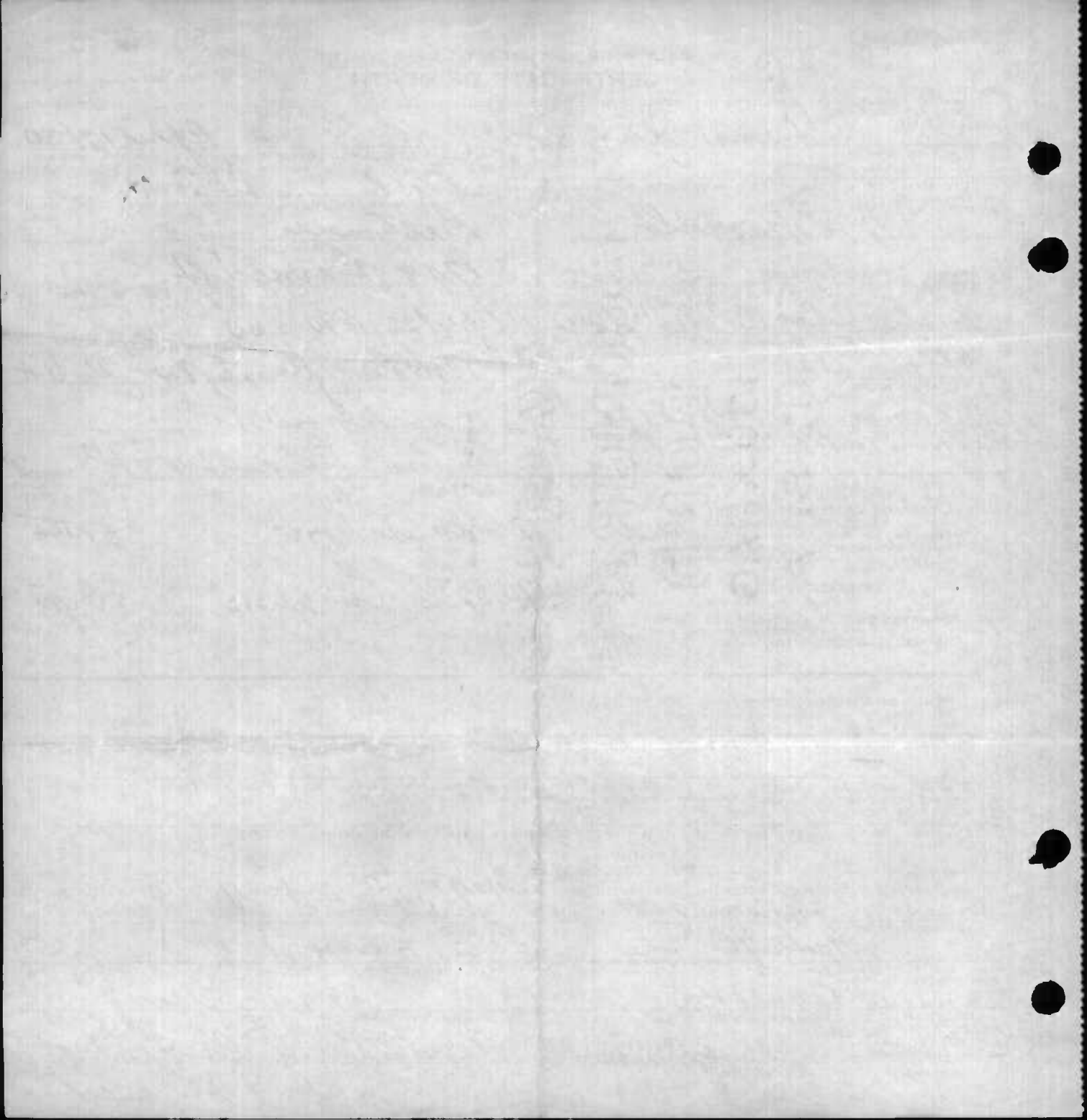
50 3673

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anna Jennings</i>		2. DATE OF DEATH <i>April 17/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1709 Barnes St.</i>		C. CITY OR TOWN <i>Baltimore</i> (If outside corporate limits, write RURAL and give township)			
c. Length of stay in Baltimore <i>5 mos.</i>		D. STREET ADDRESS (If rural, give location) <i>1709 Barnes St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>April 22, 1890</i>	9. AGE (in years last birthday) <i>59</i> 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Nottingham, County Va.</i>	
13. FATHER'S NAME <i>Charles F. Frockie</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Laura Lipicent</i>	
				ADDRESS <i>1709 Barnes St.</i>	

18. <i>581.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Malnutrition</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 mths.</i>
ANTECEDENT CAUSES		(B) <i>Hepatic Cirrhosis</i>	<i>20 yrs.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April 10, 1950</i> to <i>April 17, 1950</i> , that I last saw the deceased alive on <i>April 17, 1950</i> , and that death occurred at <i>6:30</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Francis B. Lute</i>		23B. ADDRESS <i>1501 E. Eager St.</i>		23C. DATE SIGNED <i>4/19/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>General</i>		24B. DATE <i>April 19/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>	
24D. LOCATION (City, town, or county) (State) <i>Greenwood, Va.</i>		25. FUNERAL DIRECTOR <i>Mr. Robert H. Elliott &amp; Daugherty</i>		ADDRESS <i>124 B/129 N. Cardinal St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 20 1950</i>		REGISTRAR'S SIGNATURE <i>Montgomery Williams, M.D.</i>			



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3674

Registered No. \_\_\_\_\_

B-260  
50 3674  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY A BAKER</b>			2. DATE OF DEATH <b>Apr. 19-1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2627 Cecil Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 9-07</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>2627 Cecil Ave.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Dec. 30-1899</b>		9. AGE (In years last birthday) <b>50</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT Home</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTO. Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John J. White</b>			14. MOTHER'S MAIDEN NAME <b>Bridget Patterson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Jos. B. Baker. 2627 Cecil</b>		

18. <b>171 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>II</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>Hepato-renal failure &amp; uremia</b> DUE TO  (B) <b>Generalized carcinomatous</b> DUE TO  (C) <b>Carcinoma of cervix</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>4 weeks</b>  <b>6-8 months</b>  <b>about 18 months</b>
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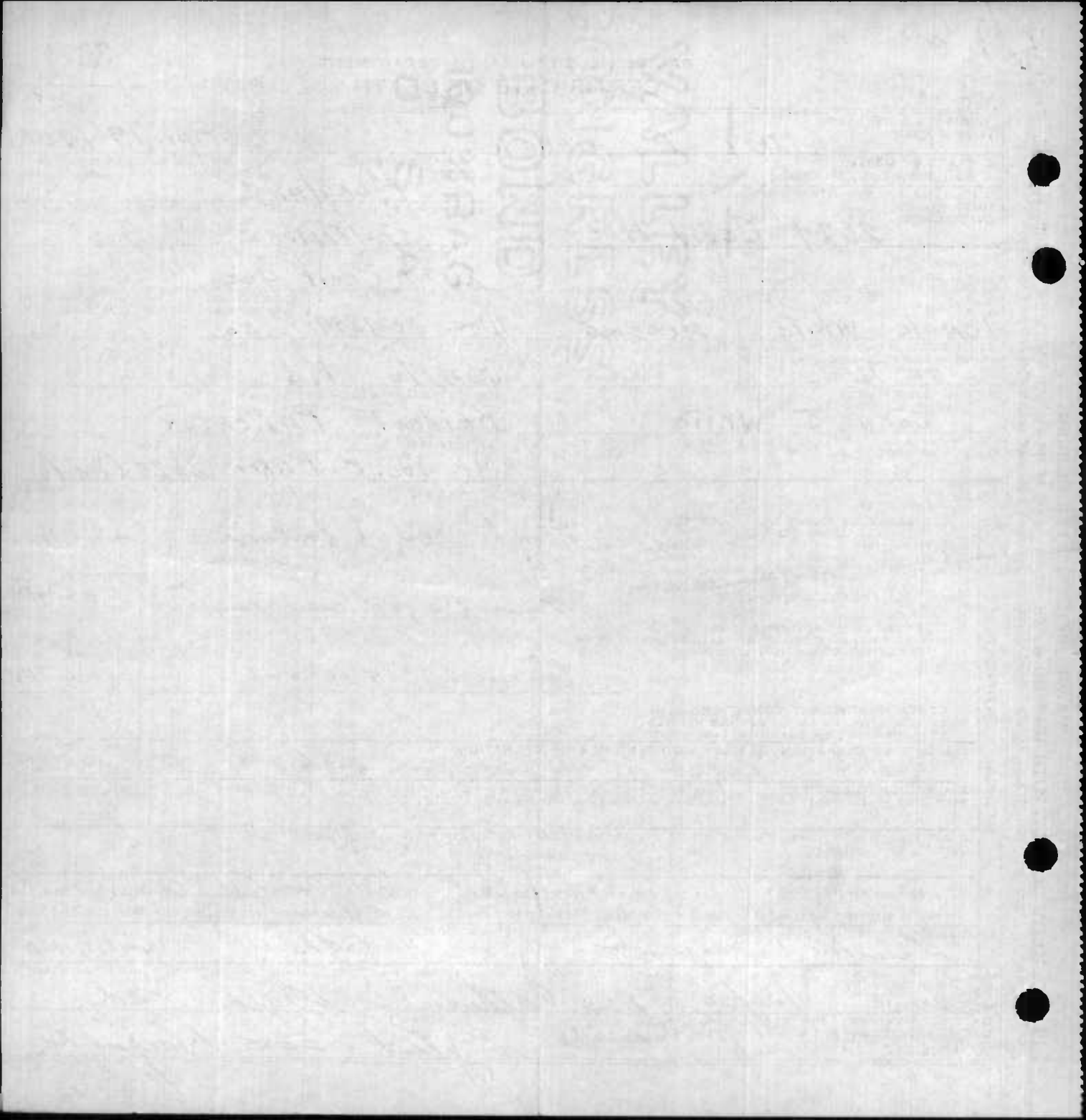
19A. DATE OF OPERATION <b>10/25/49</b>		19B. MAJOR FINDINGS OF OPERATION <b>Squamous cell carcinoma grade 2-3</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>August</b> , 1949, to <b>April 18</b> , 1950, that I last saw the deceased alive on <b>April 18</b> , 1950, and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Stevenson D. Mazzano</b>		23B. ADDRESS M. D. <b>2802 Hayford Rd 18</b>		23C. DATE SIGNED <b>April 19, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR ADDRESS <b>L. J. Luck 5305 Hayford Rd</b>			

VS 150

48a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully and legibly. The age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3675

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

August S. Freund

2. DATE  
OF  
DEATH

April 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTEMOOSE HALL  
410 W. FAYETTE ST4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE

D. STREET ADDRESS (If rural, give location)

410 W. Fayette ST.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

June 28-1885

9. AGE (In years  
last birthday)

64

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Standard Oil

10B. KIND OF BUSINESS OR INDUSTRY

MAINT. Eng.

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Phillip Freund

14. MOTHER'S MAIDEN NAME

CAROLINE EMRICH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

214-01-4206

17. INFORMANT

ADDRESS

MRS. Thelma Weinel-3648 Everslie Ave.

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC MYOCARDITIS +  
MYOCARDIAL DEGENERATION

3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hypertensive Cardio-  
Vascular Disease

3 years

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Obesity + Malnutrition

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from June 1, 1947, to April 14, 1950, that I last saw the deceased alive on April 17, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Melvin N. Borden

M. D.

23B. ADDRESS

2030 W. Fayette ST

23C. DATE SIGNED

4/19/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4-20-50

24C. NAME OF CEMETERY OR CREMATORY

Trinity

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

L. Luck 5305 Hayford St.







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 3676**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER DEMBOSKI

2. DATE  
OF  
DEATH

4-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. City

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

West Balto General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

25-05

c. Length of stay in Baltimore

40

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1612 Elmtree St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

Jan 6 1884

9. AGE (In years,

last birthday)

66

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Moulder

10B. KIND OF BUSINESS OR INDUSTRY

Mx car wheel co

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jozef Demboski

14. MOTHER'S MAIDEN NAME

Waleria Karpinska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-05-4287

17. INFORMANT

ADDRESS

Phylliss Demboski 1612 Elmtree St.

18. **526 X**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

CAUSE OF DEATH

Multiple Lung Abscesses

INTERVAL BETWEEN ONSET AND DEATH

2-3 wks

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Bronchiectasis (suppl)

unknown

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11/50, 1950, to 4/19/50, 1950, that I last saw the deceased alive on 4/17, 1950, and that death occurred at 548 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Shear

M. O.

23B. ADDRESS

West Balto Gen. Hosp

23C. DATE SIGNED

4/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/22-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

A.A. Co.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. S. Fialkowski 2007 Eastern Ave

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1915

10

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3677BIRTH NO. 50 3677

1. NAME OF DECEASED (Type or Print) <u>David Wilson</u>		2. DATE OF DEATH <u>APR 19 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ohio</u> B. COUNTY <u>V-32</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hosp.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Steubenville</u>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>R.D. 2.</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9-25-43</u>
9. AGE (In years last birthday) <u>6</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Carl Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Leona Sapp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		ADDRESS	

18. <u>754.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Failure following operation for congenital Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>4/18/50</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION <u>Tetralogy of Fallot</u>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>4-13</u> , 19 <u>50</u> , to <u>4-19</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4-19</u> , 19 <u>50</u> , and that death occurred at <u>11:00</u> m., from the causes and on the date stated above.		
23A. SIGNATURE <u>Dr. John</u>	23B. ADDRESS <u>Johns Hopkins Ho</u>	23C. DATE SIGNED <u>4/20/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24B. DATE <u>4/20/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Steubenville, Ohio</u>
24D. LOCATION (City, town, or county) (State) <u>Steubenville, Ohio</u>	25. FUNERAL DIRECTOR <u>Wm. J. Tichenor &amp; Sons</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 20 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Tichenor</u>	ADDRESS <u>157E</u>

STATE OF NEW YORK  
CERTIFICATE OF DEATH

James J. Smith

1894

1894

1894

1894

1894

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1894

MS--137267 50

3678

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3678

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alice Sarah Stokes

2. DATE  
OF  
DEATH

April 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Balto. City*

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

11-04

4940 Eastern Ave.

D. STREET ADDRESS (If rural, give location)

937 Madison Ave.

c. Length of stay in Baltimore

13 yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 13, 1913

9. AGE (In years  
last birthday)

36

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Robinson

14. MOTHER'S MAIDEN NAME

Lucy Towns

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.17. INFORMANT Baltimore City Hospitals  
Records\*4940 Eastern Ave.

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Far advanced Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 4-12-1950 to 4-18-1950, that I last saw the  
deceased alive on 4-18-1950, and that death occurred at 3:00 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

4940 Eastern Ave.

4-19-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

APR 20 1950

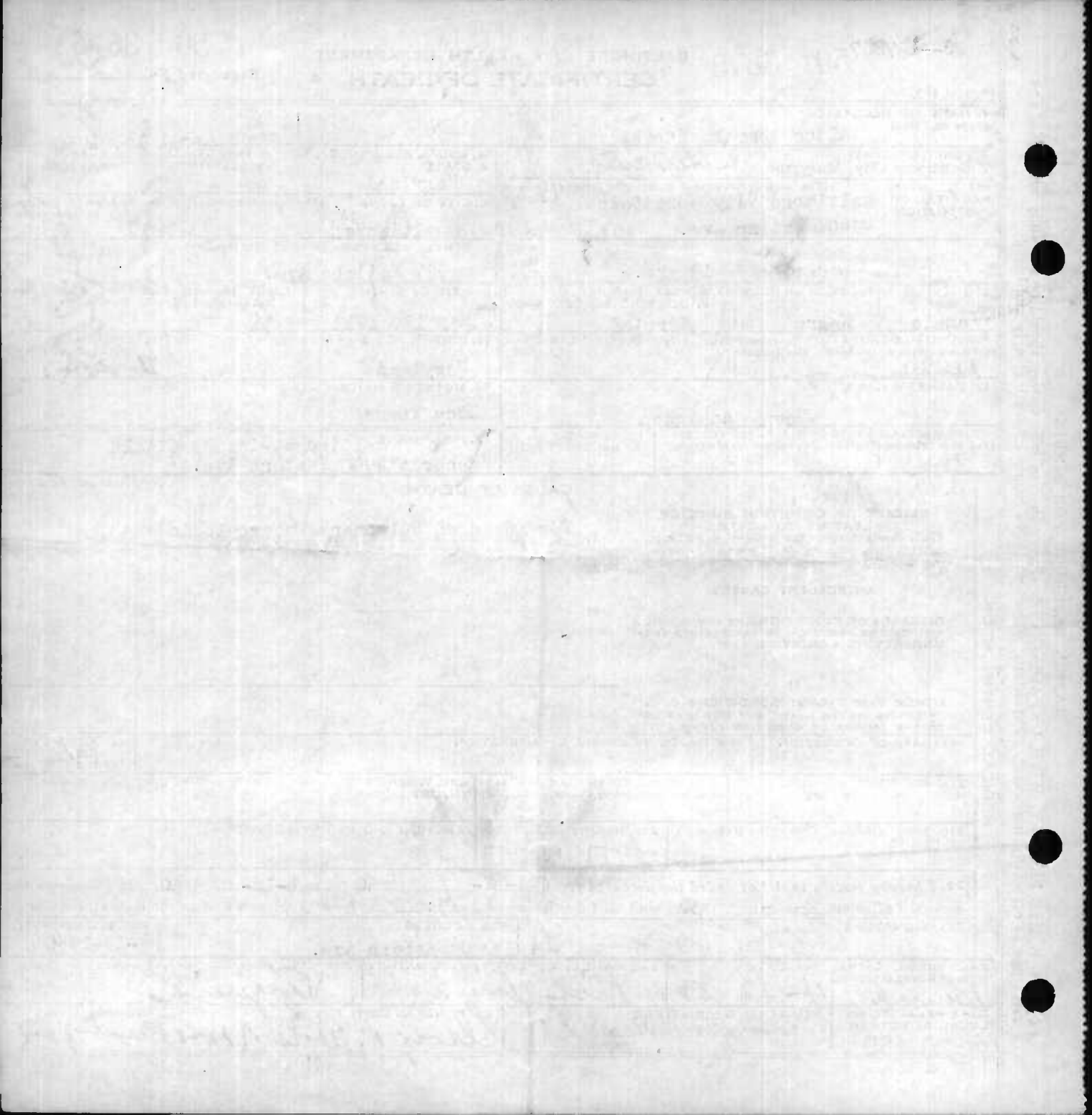
VS 150

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

EFFIE E. DAWSON

2. DATE  
OF  
DEATH

Apr. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

912 E. Eager St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

10-01

D. STREET ADDRESS (If rural, give location)

912 East Eager St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

Nov. 14, 1882

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Berry

14. MOTHER'S MAIDEN NAME

A da Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Pearl Owens, 912 E. Eager St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1950 to April 19, 1950 that I last saw the deceased alive on April 17, 1950 and that death occurred at 2:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



CERTIFICATE CORRECTED 4-21-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3680

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mrs. Edna F. Albright

2. DATE  
OF  
DEATH

4/19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Church Home &amp; Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Tork

Rural

35  
c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. ~~SINGLE~~ MARRIED

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

6/22/09 6-6-09

9. AGE (In years last birthday)

(41-) 40

11 Under 1 Year

Months: Days

12 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joseph Martin Bowers

14. MOTHER'S MAIDEN NAME

Clara Shumaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Margorie Wilbanks

18.

4/20.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Acute Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Coronary Occlusion

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

10 days

7 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 17, 1950, to April 19, 1950, that I last saw the deceased alive on April 19, 1950, and that death occurred at 5:25 P.M., from the causes and on the date stated above.

23A. SIGNATURE

George F. Myers

23B. ADDRESS

Church Home &amp; Hospital

23C. DATE SIGNED

4/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

4/23/50

24C. NAME OF CEMETERY OR CREMATORY

Tork

24D. LOCATION (City, town, or county)

Tork

(State)

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

William Williams 1214 S. Paul

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1903  
REPORT OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1902  
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS.  
1903.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3681

50 3681

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If Yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4.8.50, 19\_\_, to 4.19.50, 19\_\_, that I last saw the  
deceased alive on 4.17.50, 19\_\_ and that death occurred at 9:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

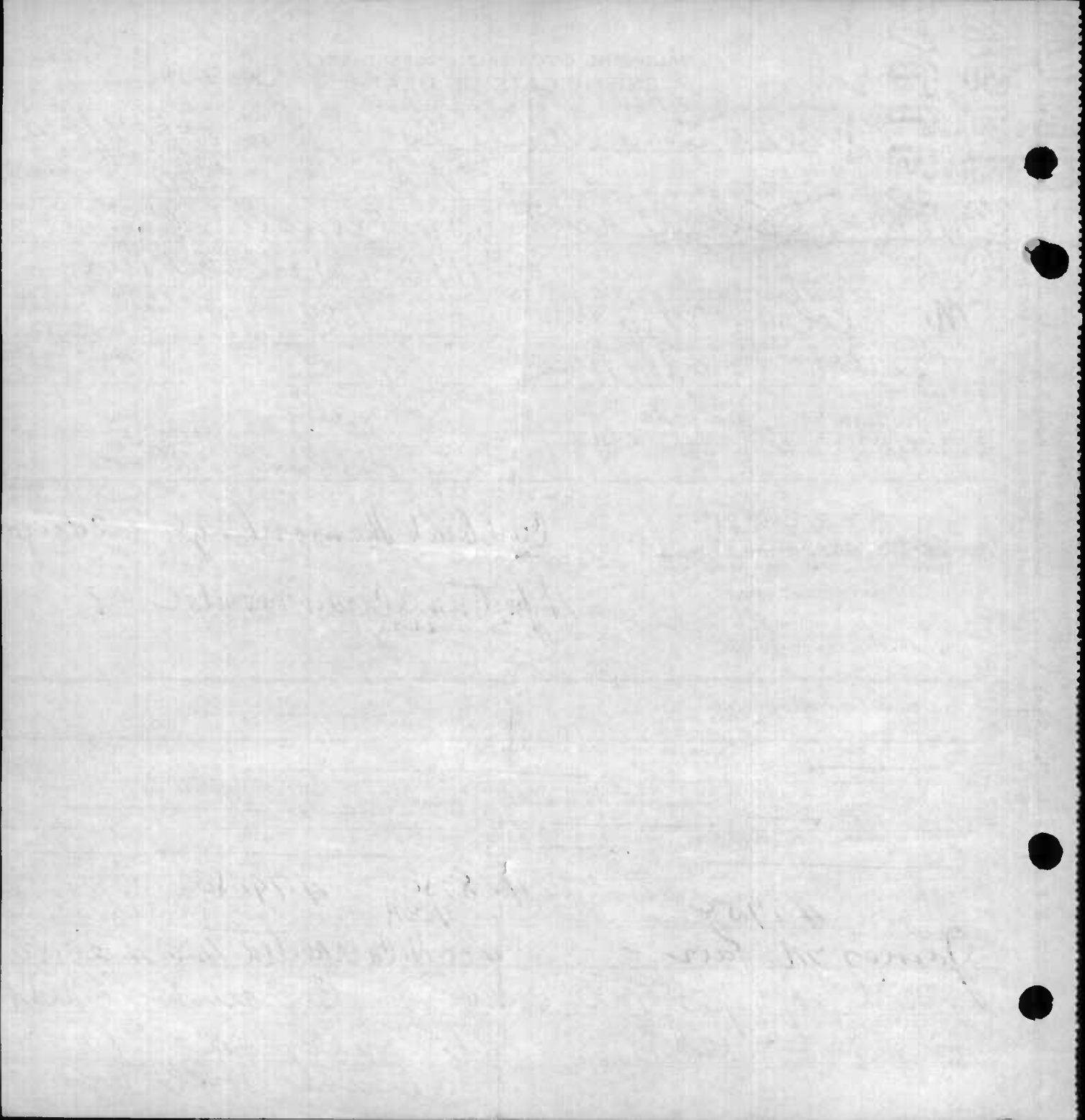
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3682

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Donald Stewart</b>		2. DATE OF DEATH <b>March 26, 1950</b>	
3. PLACE OF DEATH: a. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>27 N. Carey St. Good Samaritan Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		d. STREET ADDRESS (If rural, give location) <b>1511 Linden Ave.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>?</b>	8. DATE OF BIRTH <b>about 1871</b>
9. AGE (In years last birthday) <b>78</b>		10. Under 1 Year: Months _____ Days _____ 11. Under 24 Hours: Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>-</b>		ADDRESS	

18. <b>470.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO <b>Myocardial degeneration</b> DUE TO <b>Arteriosclerotic and hypertensive cardio vascular disease</b> DUE TO <b>Malnutrition, marked</b>	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>22 March</b> , 19 <b>50</b> , to <b>March 26</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>March 25</b> , 19 <b>50</b> , and that death occurred at <b>8:55 a.m.</b> , from the causes and on the date stated above.					
22A. SIGNATURE <b>Emil H. Hennings Jr.</b>		22B. ADDRESS <b>601 Winans Way (29)</b>		22C. DATE SIGNED <b>March 27, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>Dept. of Anatomy</b>	
24D. LOCATION (City, town, or county) (State)		<b>Univ. of Md., Medical School</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>University of Md., Medical School</b>	

VS 150

937

Chas. H. W. ...

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3683

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES W. ALBERT

2. DATE  
OF  
DEATH

Apr. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4905 Harford Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4905 Harford Avenue

c. Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 14, 1865

9. AGE (In years  
last birthday)

84

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Stationary engineer-Ret. College Blvd

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Luther Albert

14. MOTHER'S MAIDEN NAME

Sarah Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT 4905 Harford Road

Mrs. Ruby E. Albert

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

10 weeks

?

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 7, 1950, to April 18, 1950, that I last saw the  
deceased alive on April 17, 1950, and that death occurred at 7 A m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Pokorny

M. D.

23B. ADDRESS

2200 E Madison St

23C. DATE SIGNED

4/19/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

4/21/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER &amp; SONS, INC.

BALTIMORE - 13, MD.

ADDRESS

Henry F. Sander 131a

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. The first part of the paper is devoted to a review of the literature on the topic of the role of the state in the development of the economy. It is found that the state has played a significant role in the development of the economy in many countries, particularly in the case of developing countries. The state has been able to mobilize resources, provide infrastructure, and create a favorable environment for investment and growth.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Theresa M. Lotz

2. DATE  
OF  
DEATH

April 19-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

3028 Chesterfield Ave

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct 23/1871

9. AGE (In years)

78

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Thomas Bailey

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mrs. Marie Brown

ADDRESS

3028 Chesterfield Ave

18.

332x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 10, 1950, to April 19, 1950, that I last saw the deceased alive on April 16 1950, and that death occurred at 8 A.m., from the causes and on the date stated above.

23A. SIGNATURE

Walter A. Anderson

M. O.

23B. ADDRESS

3001 Shannon Drive (13) Apr. 20-50

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

4/24/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.

25. FUNERAL DIRECTOR

Philip Herwig Sons

ADDRESS

2024 Orleans St

WALLEY

COCK PEE & SONS

COND

COND

WALLEY  
COCK PEE & SONS  
COND

WALLEY  
COCK PEE & SONS  
COND

WALLEY  
COCK PEE & SONS  
COND

WALLEY  
COCK PEE & SONS  
COND



C-620

3685

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 3685

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Dr. J. Frank Crouch

2. DATE  
OF  
DEATH

April 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Latrobe Apts. - Charles &amp; Read

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Sts. Baltimore 11-02

D. STREET ADDRESS (If rural, give location)

Latrobe Apts. Charles &amp; Read Sts

c. Length of stay in Baltimore

84

Yrs.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

Dec. 30, 1865

9. AGE (In years  
last birthday)

84

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Medical Doctor

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William J. Crouch

14. MOTHER'S MAIDEN NAME

Isabella B. Christmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Alban B. Crouch, Charles &amp; Read Sts

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William J. Crouch

M.D.

23B. CHIEF MEDICAL EXAMINER..... ☐ASSISTANT MEDICAL EXAMINER..... ☐MEDICAL INVESTIGATOR..... ☒

23C. DATE SIGNED

4/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/22/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Crouch

25. FUNERAL DIRECTOR

H. H. Ullrich 2nd Son 805 N. Calvert St

ADDRESS

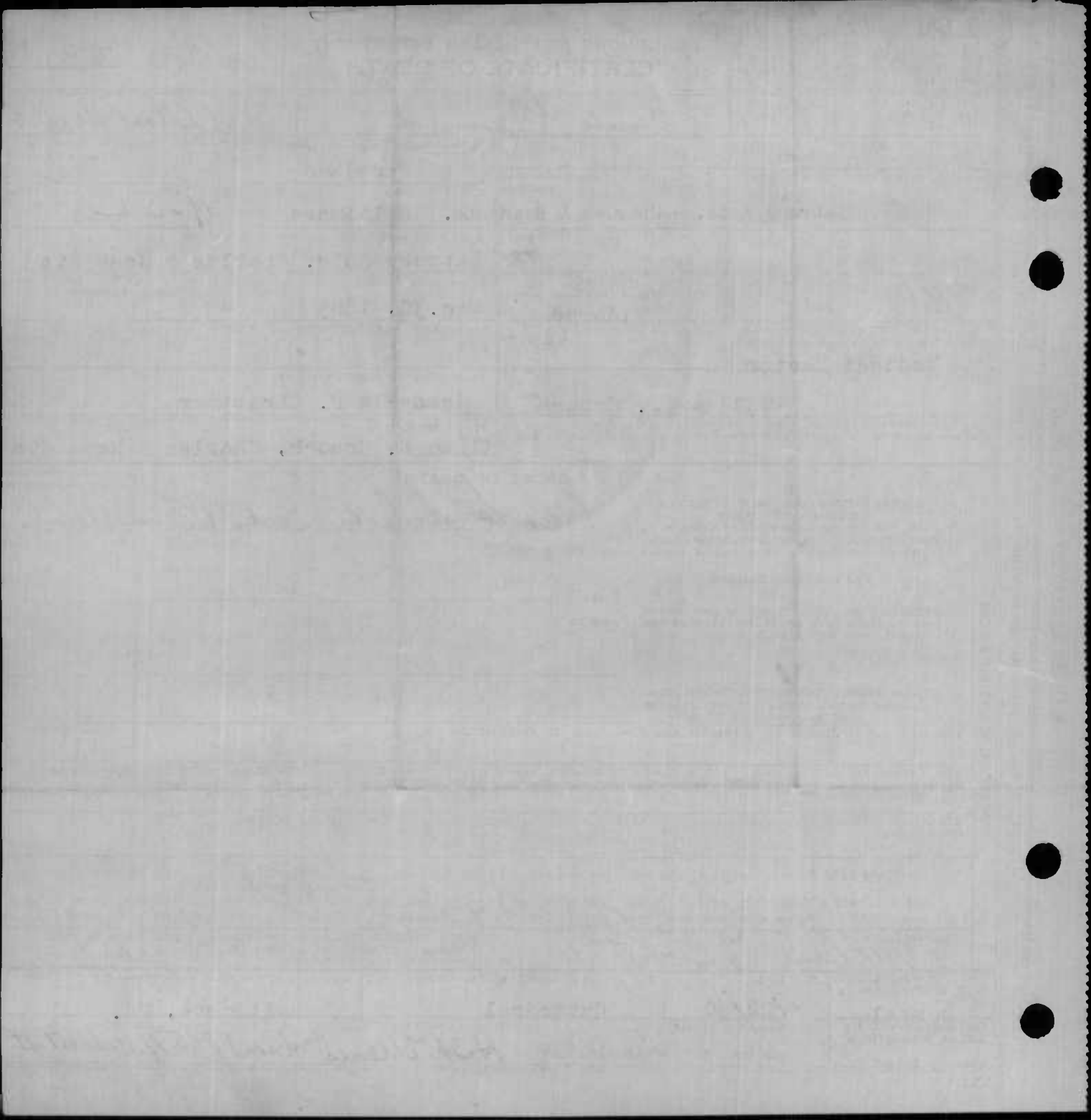
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VS 151

937

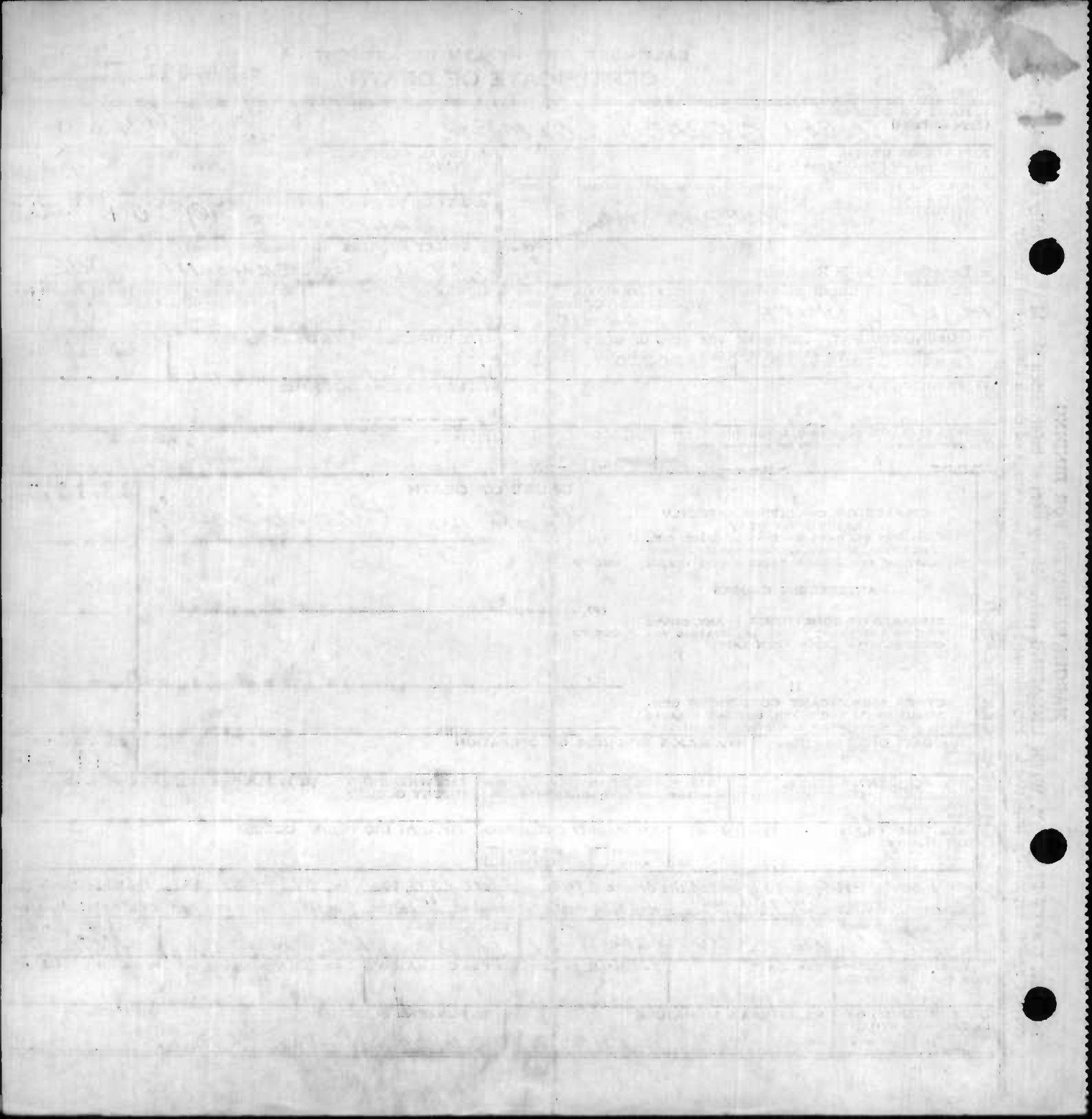
MARGIN RESERVED FOR BINDING

PLEASE WRITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3686BIRTH NO. 50 3686

1. NAME OF DECEASED (Type or Print) <b>JOSEPH GERARD OLMER</b>			2. DATE OF DEATH <b>4/19/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSP.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 9-01</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3701 GREENMOUNT AVE</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Feb. 10, 1900</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Credit Manager American Oil Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George F. Olmer</b>		
14. MOTHER'S MAIDEN NAME <b>-----</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>251-05-5808</b>	
17. INFORMANT <b>Nancy C. Olmer</b>			ADDRESS <b>3701 Greenmount Ave</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			DUE TO		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/11/50</b> , 19__, to <b>4/19/50</b> , 19__, that I last saw the deceased alive on <b>4/18/50</b> and that death occurred <b>5:10 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Thaddeus Swornick</b>		23B. ADDRESS <b>St. Joseph's Hosp.</b>		23C. DATE SIGNED <b>4/19/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		25. FUNERAL DIRECTOR <b>John A. Moran</b>		ADDRESS <b>3000 E. B. Balto. S.</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully verified. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

600  
50 3687  
BIRTH NO.

50 3687

1. NAME OF DECEASED (Type or Print) <b>Dolly Hawkins Carr</b>		2. DATE OF DEATH <b>17 April 50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Good Samaritan Home</b> <b>27 N. Carey Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. Length of stay in Baltimore <b>Lifetime</b>		D. STREET ADDRESS (If rural, give location) <b>2000 N. Bentalou Street</b>	
7. SEX <b>FEMALE</b>	8. COLOR OR RACE <b>Col.</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	10. DATE OF BIRTH <b>June 5, 1887</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	13. AGE (In years last birthday) <b>62-63</b>	14. Under 1 Year Months: Days
15. FATHER'S NAME <b>David Hawkins</b>		16. CITIZEN OF WHAT COUNTRY?	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		18. SOCIAL SECURITY NO.	
19. MOTHER'S MAIDEN NAME <b>/ ?</b>		20. INFORMANT ADDRESS <b>Roland Carr 2000 N. Bentalou St., Balt., Md.</b>	
21. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Hypertension and arteriosclerosis</b> II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cardio-vascular renal disease</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
22. DATE OF OPERATION <b>0</b>		23. MAJOR FINDINGS OF OPERATION	
24. ACCIDENT, SUICIDE, HOMICIDE (Specify)		25. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		27. TIME (Month) (Day) (Year) (Hour) OF INJURY	
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
30. I hereby certify that I attended the deceased from <b>15 June, 1949</b> to <b>17 April, 1950</b> , that I last saw the deceased alive on <b>17 April, 1950</b> , and that death occurred at <b>9 A</b> m., from the causes and on the date stated above.			
31. SIGNATURE <b>Emil H. Henning Jr.</b>		32. ADDRESS <b>601 Winans Way</b>	
33. DATE SIGNED <b>17 April 50</b>		34. DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>	
35. REGISTRAR'S SIGNATURE <b>Walter J. Williams, M.D.</b>		36. FUNERAL DIRECTOR ADDRESS <b>Joseph L. Russ 1200 McCulloh St., Balt., Md.</b>	

YS 150

131a

STATE OF TEXAS  
CERTIFICATE OF MARRIAGE

1-1-1900  
1-1-1900  
1-1-1900

I, the undersigned, County Clerk of the County of \_\_\_\_\_ State of Texas, do hereby certify that on the \_\_\_\_\_ day of \_\_\_\_\_ 1900, at \_\_\_\_\_ in the County of \_\_\_\_\_ State of Texas, \_\_\_\_\_ and \_\_\_\_\_ were by me joined together in Holy Matrimony according to the rites and ceremonies of the \_\_\_\_\_ and the laws of the State of Texas, and that the same were then and there lawfully wedded.

WITNESSES MY HAND AND SEAL OF OFFICE this \_\_\_\_\_ day of \_\_\_\_\_ 1900.

\_\_\_\_\_  
County Clerk of the County of \_\_\_\_\_ State of Texas



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3688BIRTH NO. 50 36881. NAME OF DECEASED  
(Type or Print)JAMES EDWARDS2. DATE  
OF  
DEATH19 April 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION22 Good Samaritan Hosp.  
227 N. Carey St

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATEmd

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 10-02D. STREET ADDRESS (If rural, give location)  
818 N. Eden St.

5. SEX

Male

6. COLOR OR RACE

Colored7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Widowed

8. DATE OF BIRTH

March 10, 1863

9. AGE (In years last birthday)

87

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Porter

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

J

14. MOTHER'S MAIDEN NAME

J15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Record18. 443XDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Cerebral ThrombosisDUE TO Hypertensive and  
arteriosclerotic cardio-vascular  
Disease

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 April, 1950, to 19 April, 1950, that I last saw the deceased alive on 19 April, 1950, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Emil H. Henning Jr.

M. D.

23B. ADDRESS

601 Winans Way

23C. DATE SIGNED

21 April 5024A. BURIAL, CREMA-  
TION REMOVAL (Specify)Burial

24B. DATE

April 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

2nd. Calvary

24D. LOCATION (City, town, or county)

Brooklyn, md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Joseph L. Rust, 1208 McCulloch St.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3689  
Registered No.

1. NAME OF DECEASED  
(Type or Print) **KENNETH SHARP**

2. DATE OF DEATH **April 20, 1950**

3. PLACE OF DEATH:  
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

**1227 Madison Avenue**

D. STREET ADDRESS (If rural, give location)  
**1227 Madison Avenue**

c. Length of stay in Baltimore

5. SEX

**male**

6. COLOR OR RACE

**colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**single**

8. DATE OF BIRTH

**Feb. 27, 1950**

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**none**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

**Mary Sharp**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Mary Sharp 1227 Madison Ave. Balt.**

18. **763.0** **A92x**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

**Focal interstitial pneumonitis**

OE TO

ANTECEDENT CAUSES

**137 6 91** **A92 3**  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**R. S. Fisher**

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED **April 20, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE **April 21, 1950**

24C. NAME OF CEMETERY OR CREMATORY **Mt. Auburn**

24D. LOCATION (City, town, or county) (State) **Westport, 22nd.**

DATE RECEIVED BY LOCAL REGISTRAR

**APR 21 1950**

REGISTRAR'S SIGNATURE

**William Williams, M.D.**

25. FUNERAL DIRECTOR

**Charles H. Alexander 1300 McCall St.**

ADDRESS

**114E**

Mr Titus changed side

763.0 to 492.0

5/11/11

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3690BIRTH NO. 50 36901. NAME OF DECEASED  
(Type or Print)

KARL K. FALKENSTEIN

2. DATE  
OF  
DEATH

April 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)  
504 E. 41st St.4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
504 E. 41st St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Dec. 10, 1890

9. AGE (In years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
salesman10B. KIND OF BUSINESS OR  
INDUSTRY  
Baby Products

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry M. Falkenstein

14. MOTHER'S MAIDEN NAME

Margaret Boring

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Viola E. Falkenstein 504 E. 41st St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

A.

Adenocarcinoma of colon  
with metastases to liver & lungsINTERVAL BETWEEN  
ONSET AND DEATH

5 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

B.

DUE TO

C.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

29 Dec 1949

19B. MAJOR FINDINGS OF OPERATION

Adenocarcinoma hepatic flexure colon

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

22. I hereby certify that I attended the deceased from 6 April, 1950, to 19 April, 1950, that I last saw the deceased alive on 19 April, 1950, and that death occurred at 9:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1531 E North Ave

21 April 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

4/22/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 21 1950

Wilmington Williams, Md.

Wm. J. Vichner &amp; Sons Balto Md.

CERTIFICATE OF DEATH

STATE OF NEW YORK

NO. 1

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3691

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Walter Gustavus Kelly</b>			2. DATE OF DEATH <b>April 20, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>503-NOTTINGHAM RD.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>503-NOTTINGHAM RD.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 28-04</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>503-NOTTINGHAM RD.</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>SEPT. 23, 1865</b>		9. AGE (In years last birthday) Months: <b>84</b> Days: <b>6</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DRY GOODS</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>OWEN KELLY</b>			14. MOTHER'S MAIDEN NAME <b>MATILDA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>577-01-9391</b>		17. INFORMANT ADDRESS <b>MR. OWEN W. KELLY 503-NOTTINGHAM RD</b>

18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Coronary Occlusion, Acute</b> DUE TO <b>15 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Arteriosclerotic Heart Disease</b> DUE TO <b>About .5 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May, 1947, to April 20, 1950, that I last saw the deceased alive on April 20, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <b>1 Malvern Hill, Baltimore, Md.</b>		23C. DATE SIGNED <b>4/20/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>DURIAL</b>		24B. DATE <b>4/24/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY WASH. D.C.</b>	
24D. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>					

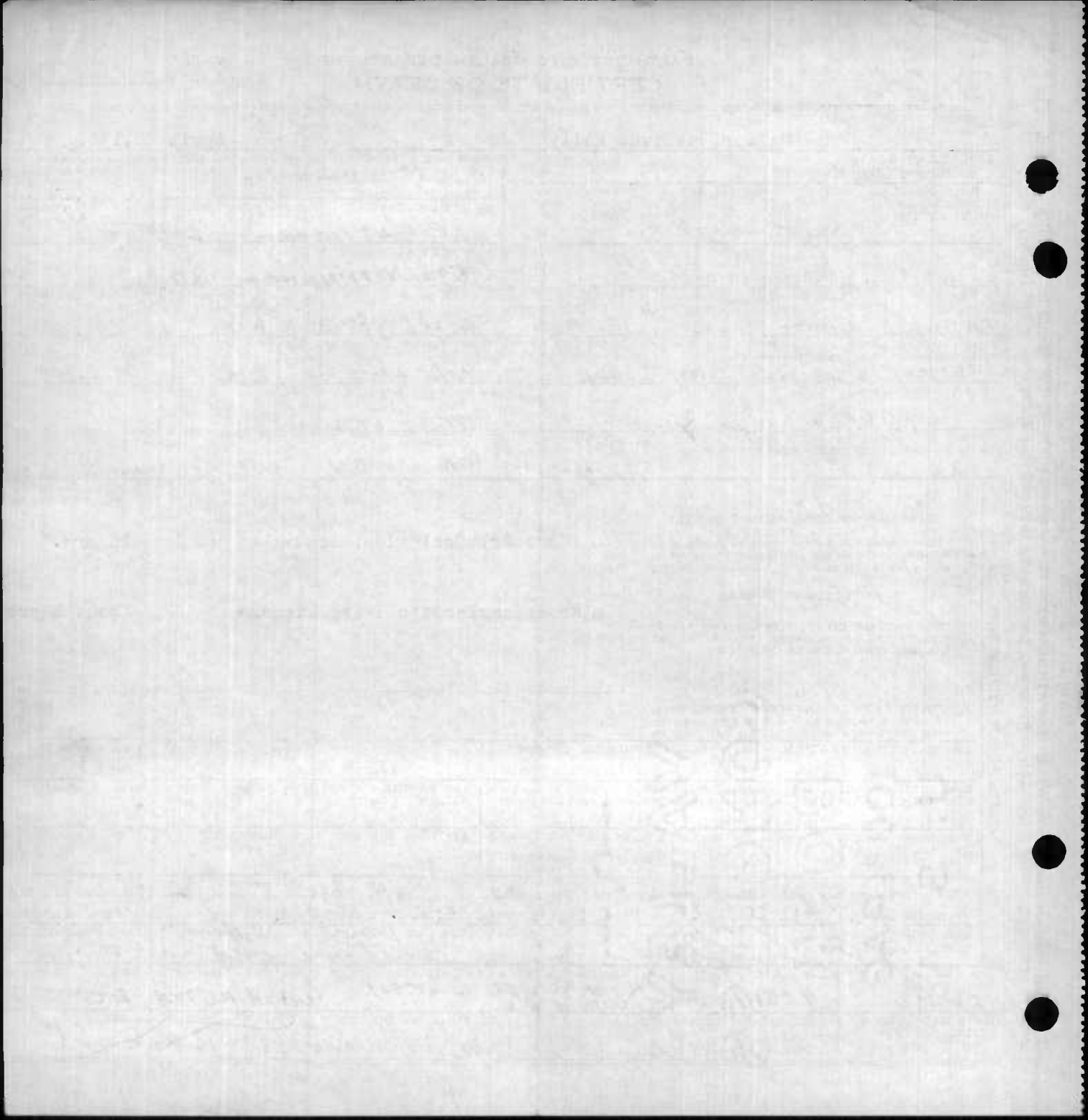
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR ADDRESS <b>The S. H. McKines Co. Wash, D.C.</b>	
--	--	---	--	---	--

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3692  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Christopher

Tiggles

2. DATE  
OF  
DEATH

April 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

1127 N. Parish St.

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

1127 N. Parrish St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 8, 1911

9. AGE (In years  
last birthday)

38

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Allen Tiggle

14. MOTHER'S MAIDEN NAME

Monie Harcum

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Monie Tiggle 1105 Divison st.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*B. Fisher*23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED  
April 18, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-22-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Baltimore,

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Thurston Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*Mrs. Frances A. Hensley*

578 W. Biddle St.

VS 151

98499

(Mrs) Frances A. Hensley

921

✓

USE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The  
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of mortuary		18. Signature of funeral director		19. Signature of funeral home		20. Signature of cemetery	
21. Signature of church		22. Signature of mortuary		23. Signature of funeral director		24. Signature of funeral home	
25. Signature of cemetery		26. Signature of church		27. Signature of mortuary		28. Signature of funeral director	
29. Signature of funeral home		30. Signature of cemetery		31. Signature of church		32. Signature of mortuary	
33. Signature of funeral director		34. Signature of funeral home		35. Signature of cemetery		36. Signature of church	
37. Signature of mortuary		38. Signature of funeral director		39. Signature of funeral home		40. Signature of cemetery	
41. Signature of church		42. Signature of mortuary		43. Signature of funeral director		44. Signature of funeral home	
45. Signature of cemetery		46. Signature of church		47. Signature of mortuary		48. Signature of funeral director	
49. Signature of funeral home		50. Signature of cemetery		51. Signature of church		52. Signature of mortuary	
53. Signature of funeral director		54. Signature of funeral home		55. Signature of cemetery		56. Signature of church	
57. Signature of mortuary		58. Signature of funeral director		59. Signature of funeral home		60. Signature of cemetery	
61. Signature of church		62. Signature of mortuary		63. Signature of funeral director		64. Signature of funeral home	
65. Signature of cemetery		66. Signature of church		67. Signature of mortuary		68. Signature of funeral director	
69. Signature of funeral home		70. Signature of cemetery		71. Signature of church		72. Signature of mortuary	
73. Signature of funeral director		74. Signature of funeral home		75. Signature of cemetery		76. Signature of church	
77. Signature of mortuary		78. Signature of funeral director		79. Signature of funeral home		80. Signature of cemetery	
81. Signature of church		82. Signature of mortuary		83. Signature of funeral director		84. Signature of funeral home	
85. Signature of cemetery		86. Signature of church		87. Signature of mortuary		88. Signature of funeral director	
89. Signature of funeral home		90. Signature of cemetery		91. Signature of church		92. Signature of mortuary	
93. Signature of funeral director		94. Signature of funeral home		95. Signature of cemetery		96. Signature of church	
97. Signature of mortuary		98. Signature of funeral director		99. Signature of funeral home		100. Signature of cemetery	



WARE  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3693  
Registered No.

W 600  
50 3693  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Ware, Evelyn Felicia</b>		2. DATE OF DEATH <b>9/19/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1519 Division St</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 19-01</b>	
c. Length of stay in Baltimore <b>23</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>308 Carey Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Aug 11 1926</b>
9. AGE (In years last birthday) <b>23</b>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Ware</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

MEDICAL CERTIFICATION

18. <b>251X</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>Respiratory Failure</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <b>Bronchial Occlusion</b> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <b>Bronchial Secretions</b> <b>Thyrotoxicosis</b>		
19A. DATE OF OPERATION <b>4/19/50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Adenomatous goiter</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>3/10</b> , 19 <b>50</b> , to <b>9/19</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/19/50</b> , 19 <b>50</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>Dr. Marcus W. Moore</b>	23B. ADDRESS <b>Provident Hospital</b>	23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-22-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>Mr. Frances A. Gentry</b> ADDRESS <b>578 W. Biddle St</b>

RECEIVED 10/17/1933



W 420

Welch

50 3694

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

George Welch

2. DATE  
OF  
DEATH

APR 19 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHN HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 7-05

D. STREET ADDRESS (If rural, give location)

1641 E. Madison

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. ~~026X~~, 026X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Cerebral Thrombosis

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ? Central Nervous system syphilis

DUE TO

Known 3 mos

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Syphilitic aortitis, aortic insufficiency

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK NOT WHILE AT WORK

22. I hereby certify that I attended the deceased from 4-4-1950 to 4-19-1950, that I last saw the deceased alive on 4-19-1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Davis E. Ryan, D.

23B. ADDRESS

JOHN HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 21 1950

Wilmington Williams, Md

1631 1st Street Hill Ave

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,  
January 10, 1901.  
REPORT  
OF THE  
ATTORNEY GENERAL,  
JAMES C. CLARK.

ALBANY:  
JAMES C. CLARK,  
ATTORNEY GENERAL,  
1901.

ALBANY:  
JAMES C. CLARK,  
ATTORNEY GENERAL,  
1901.

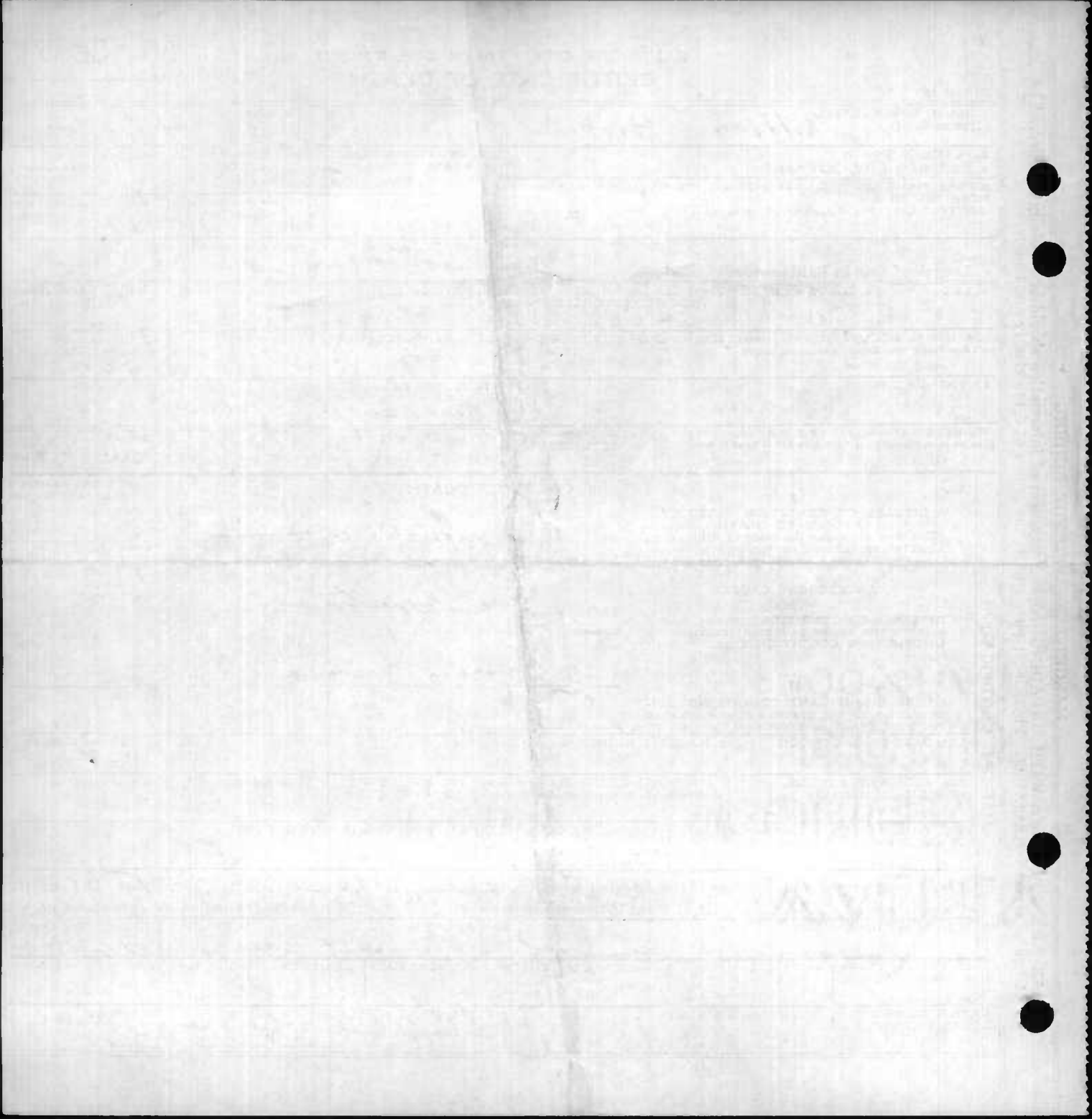
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3695

Registered No.

BIRTH NO. 50 3695		1. NAME OF DECEASED (Type or Print) <i>Lillian Hill</i>		2. DATE OF DEATH <i>4/18/50</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY			
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hosp</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 11-04</i>			
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <i>431 Cummings Ct.</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOW</i>	8. DATE OF BIRTH <i>10/6/1890</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>ESSEX Co. VA.</i>	
13. FATHER'S NAME <i>Zachariah Young</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH SMITH</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MRS. Naomi Y. HARDY 2528 Madison Ave.</i>	
18. <i>444X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Hypostatic pneumonia</i> DUE TO (B) <i>Ess. hypertension</i> (C) <i>Anorexia nervosa</i>		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/10, 1950</i> , to <i>4/18, 1950</i> , that I last saw the deceased alive on <i>4/18, 1950</i> , and that death occurred at <i>8:25 p.m.</i> , from the causes and on the date stated above.					
23a. SIGNATURE <i>Lillian W. Hill</i>		23b. ADDRESS <i>Therment House</i>		23c. DATE SIGNED <i>4/20/50</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>4/21/1950</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25. FUNERAL DIRECTOR <i>Holland Funeral Home</i>		ADDRESS <i>1631 Druid Hill Ave.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 21 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams</i>			



## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 3696

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Baby EWALT

2. DATE  
OF  
DEATH

4/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

women's hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL FOR WOMEN  
OF MARYLAND

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Millersville

5200

c. Length of stay in Baltimore

16 hours

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

"Beverly Hall"

5. SEX

MALE

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

4/20/50

9. AGE (In years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

16 13

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Walther EWALT

14. MOTHER'S MAIDEN NAME

CLAIRE Lucille STALFORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

Above

18. 766.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Birth-cerebral Hemorrhage

16 hrs

DUE TO

13 min

ANTECEDENT CAUSES

(B)

Precipitate birth

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

Blood dyscrasia?

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 4/20/1950 to 4-21/1950, that I last saw the  
deceased alive on 4-21/1950, and that death occurred at 12:45 A.m., from the causes and on the date stated above.

23A. SIGNATURE

1070 Gray

23B. ADDRESS

1014 St Paul St

23C. DATE SIGNED

4/21/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/21/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

William J. Vickner

ADDRESS

160a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3697

Registered No.

50 3697  
BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Haden Barrows

2. DATE  
OF  
DEATH

Apr. 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

2

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

758.2  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

(A)

DUE TO

MENINGITIS (B. COLI)  
(WOUND INFECTION)

2 MONTHS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

OXYCEPHALY (WITH  
INTERNAL HYDROCEPHALUS)  
PLATYBASIA

46 YEARS

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

FEB 15, 1950

PLATYBASIA WITH

OBSTRUCTION OF CISTERNA MAGNA

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 2/14, 1950, to 4/20, 1950, that I last saw the  
deceased alive on 4/20, 1950, and that death occurred at 1 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Robert E. Green M. D.

JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4-22-1950

Odessa

Odessa, Texas

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 21 1950

Thurston Williams, M.D.

John O. Mitchell Sons 1900 Eutaw Place

*Cerithium dilleri*

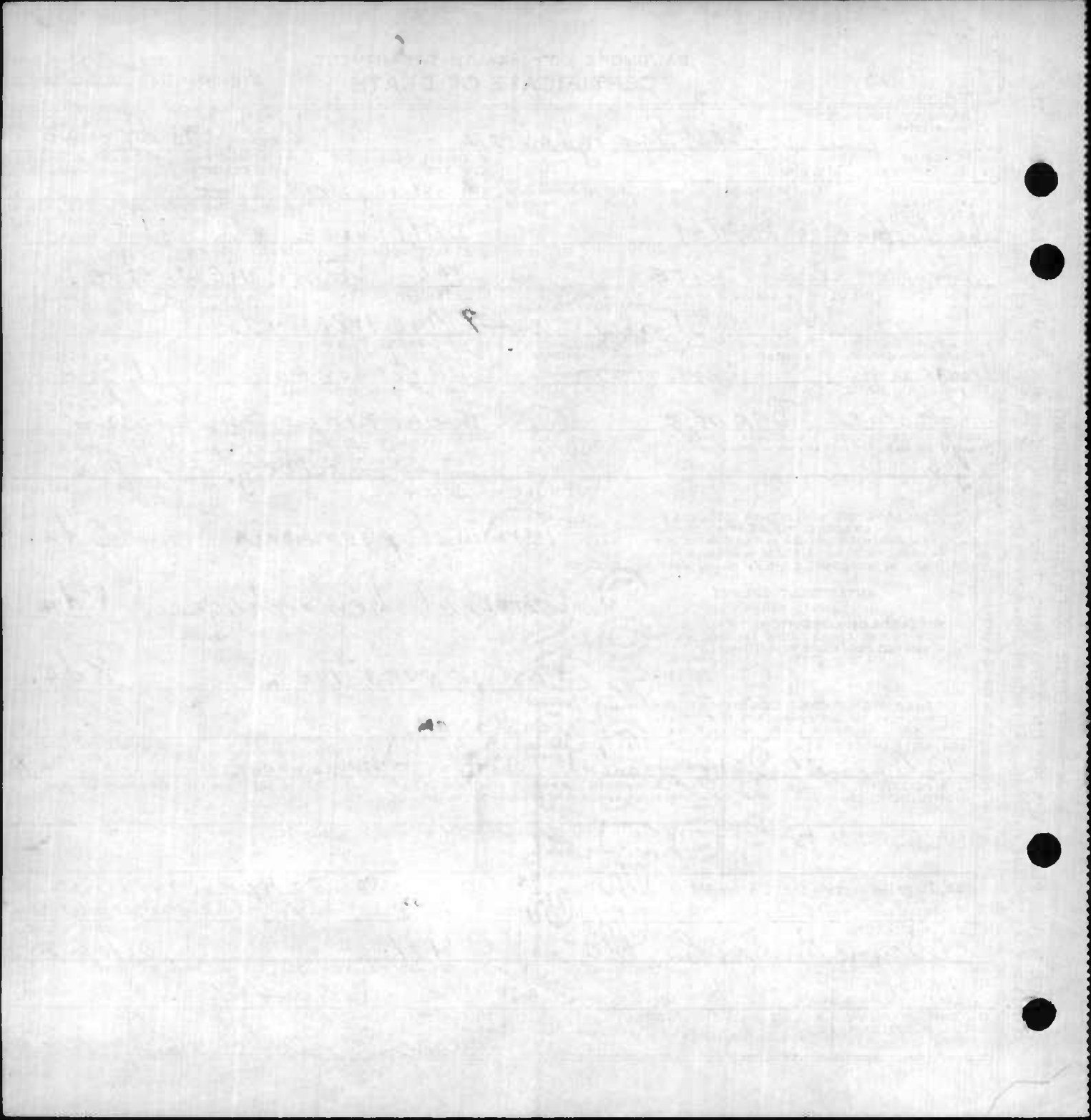
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3698

BIRTH NO. 562

1. NAME OF DECEASED (Type or Print) <u>Mrs. Bertha M. Homfighausen</u>		2. DATE OF DEATH <u>20 Apr '50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>—</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home &amp; Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 15-08A</u>	
C. Length of stay in Baltimore <u>Life</u>		D. STREET ADDRESS (If rural, give location) <u>3407 FAIRVIEW AVE.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single &amp; married</u>	8. DATE OF BIRTH <u>29 MAR 1884</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>66</u>
13. FATHER'S NAME <u>George BEAVER</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or if unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Paul F. Homfighausen</u>

MEDICAL CERTIFICATION	18. <u>331X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <u>Terminal pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3da.</u>
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <u>Cerebral hemorrhage</u>		<u>8da.</u>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C) <u>Post operative</u>		<u>8da.</u>
	<u>Hypertension</u>		<u>?</u>
19A. DATE OF OPERATION <u>13 Apr 50.</u>		19B. MAJOR FINDINGS OF OPERATION <u>Pre frontal lobotomy - hemorrhage</u>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>13 Apr 1950</u> , to <u>20 Apr 1950</u> , that I last saw the deceased alive on <u>20 Apr 1950</u> , and that death occurred at <u>12:22</u> m., from the causes and on the date stated above.			
23A. SIGNATURE <u>Wayne N. Sachs M.D.</u>		23B. ADDRESS <u>CHH.</u>	
23C. DATE SIGNED <u>20 Apr 50</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/24/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Landon Pk.</u>	24D. LOCATION (City, town, or county) (State) <u>3801 Fresh Rd. / Balt. Ind.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 21 1950</u>	REGISTRAR'S SIGNATURE <u>William Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>Harry H. Witzke</u> ADDRESS <u>4101 Edmondson</u>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3699  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bessie Moore

2. DATE  
OF  
DEATH

4/16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

934 Stoddard Court

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

934 Stoddard Ct

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 9, 1890, 60

9. AGE (In years last birthday)

H Under 1 Year Months: Days

H Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Idanover Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Dobson

14. MOTHER'S MAIDEN NAME

Lucinda ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Albert Moore. 934 Stoddard Ct.

18. 156.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Carcinoma Liver

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/1, 1950, to 4/16, 1950, that I last saw the deceased alive on 4/16, 1950, and that death occurred at 11 p. m., from the causes and on the date stated above.

23A. SIGNATURE

B. R. R. R. S.

M. D.

23B. ADDRESS

2133 D. Hill a

23C. DATE SIGNED

4/16

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial 4-22-1950

Mt. Auburn Cem. Balto.

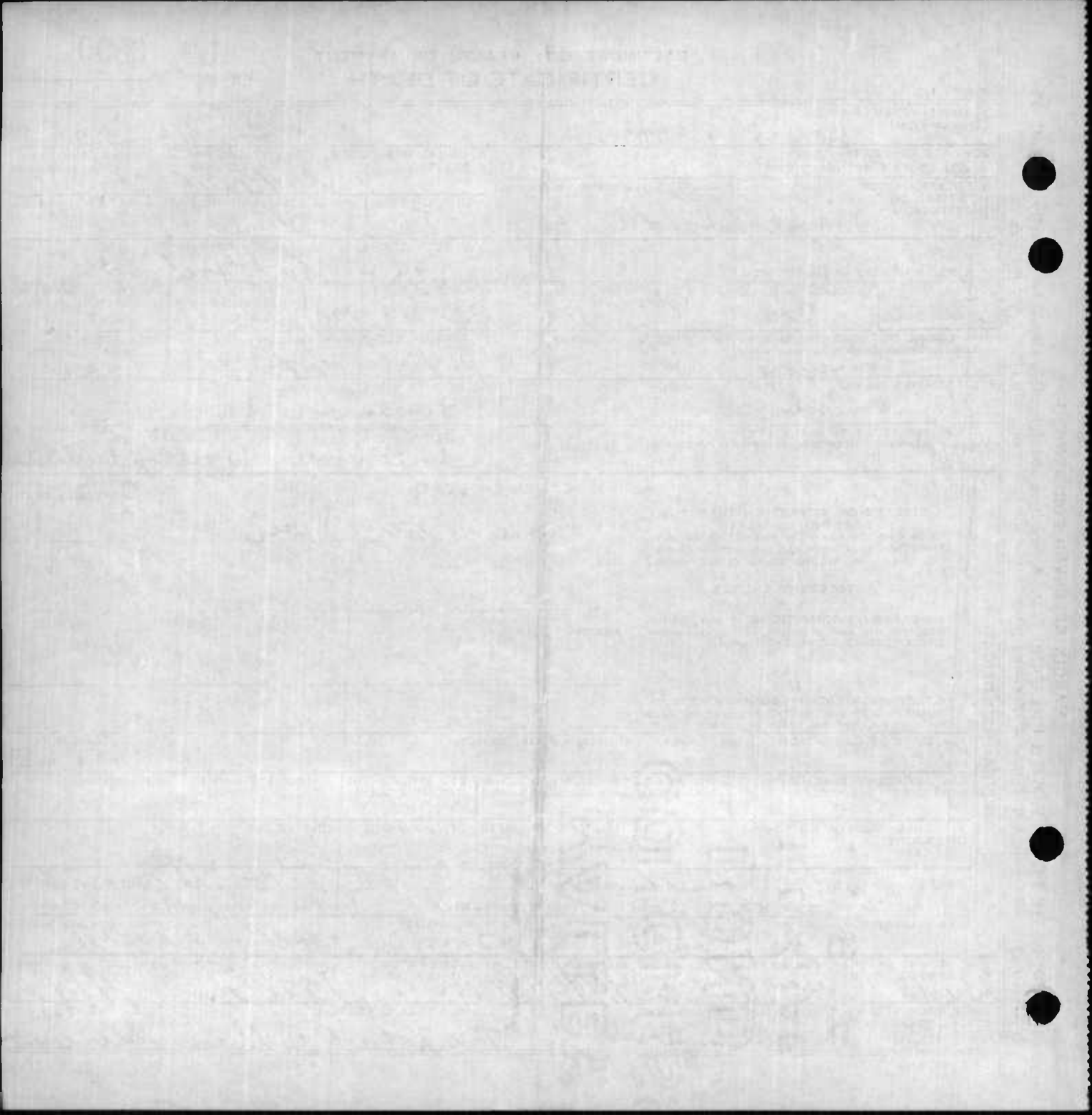
322N

APR 22 1950

T. Williams, M.D.

Mrs. Kate R. Williams







S-632  
MS-137431

50 3700

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3700  
Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>William Shorts</b>			2. DATE OF DEATH <b>4-20-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundal</b>					
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>RURAL--Crownsville, Md. 25-33</b>			D. STREET ADDRESS (If rural, give location) <b>2607 Huron St.</b> <b>Crownsville State Hospital</b>		
c. Length of stay in Baltimore <b>?</b>			Yrs. Mos. Days					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Feb. 29, 1916</b>		9. AGE (In years last birthday) <b>34</b>		H Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Mt. Winans Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Shorts</b>			14. MOTHER'S MAIDEN NAME <b>Mary Robinson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Baltimore City Hospitals</b> <b>Records* 4940 Eastern Ave.</b>		

18. <b>3003</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) Asphyxia</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Convulsive seizure--etiology undetermined</b> DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Psychosis schizophrenia</b>							
19A. DATE OF OPERATION <b>4-8-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Paranoid schizophrenia</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>4-19-</b> , 1950 to <b>4-20-</b> , 1950, that I last saw the deceased alive on <b>4-20-</b> , 1950, and that death occurred at <b>7:00 a.m.</b> , from the causes and on the date stated above.							
23A. SIGNATURE <b>[Signature]</b> M. D.				23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>4-20-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-23-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem. Balto.</b>		24D. LOCATION (City, town, or county) (State) <b>Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>		ADDRESS <b>9. Schroeder</b>	

98899

8412

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

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DATE OF ARRIVAL

PLACE OF ARRIVAL

MS--136914

50 3701 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3701  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Levi Bush

2. DATE  
OF  
DEATH 4-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTEBaltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

18-01

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

942 Bennett Place

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 11, 1862

9. AGE (In years last birthday)

87

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

Factory

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Levi Bush

14. MOTHER'S MAIDEN NAME

Eleanor Dyson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records\*4940 Eastern Ave.

18.

600.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pyelonephritis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28-\_\_\_\_, 1950, to 4-18-\_\_\_\_, 1950 that I last saw the deceased alive on 4-18-\_\_\_\_, 1950, and that death occurred at 3:25 P.m., from the causes and on the date stated above.

23A. SIGNATURE

J. P. O'Brien M.D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-19-1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 21 1950

Custington Williams, M.D.

Mrs. Katherine Williams

J. Schroeder

133a

STATE OF TEXAS  
COUNTY OF \_\_\_\_\_  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Occupation		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Minister of Religion	
13. Name of Coroner		14. Name of Jury Foreman		15. Name of Jury Members		16. Name of Witnesses	
17. Name of Medical Examiner		18. Name of Pathologist		19. Name of Anatomist		20. Name of Surgeon	
21. Name of Dentist		22. Name of Pharmacist		23. Name of Nurse		24. Name of Midwife	
25. Name of Embalmer		26. Name of Funeral Home		27. Name of Cemetery		28. Name of Grave	
29. Name of Interment		30. Name of Burial		31. Name of Cremation		32. Name of Disposition	
33. Name of Reburial		34. Name of Exhumation		35. Name of Removal		36. Name of Transfer	
37. Name of Relocation		38. Name of Disposal		39. Name of Burial		40. Name of Interment	
41. Name of Burial		42. Name of Interment		43. Name of Cremation		44. Name of Disposition	
45. Name of Reburial		46. Name of Exhumation		47. Name of Removal		48. Name of Transfer	
49. Name of Relocation		50. Name of Disposal		51. Name of Burial		52. Name of Interment	
53. Name of Burial		54. Name of Interment		55. Name of Cremation		56. Name of Disposition	
57. Name of Reburial		58. Name of Exhumation		59. Name of Removal		60. Name of Transfer	
61. Name of Relocation		62. Name of Disposal		63. Name of Burial		64. Name of Interment	
65. Name of Burial		66. Name of Interment		67. Name of Cremation		68. Name of Disposition	
69. Name of Reburial		70. Name of Exhumation		71. Name of Removal		72. Name of Transfer	
73. Name of Relocation		74. Name of Disposal		75. Name of Burial		76. Name of Interment	
77. Name of Burial		78. Name of Interment		79. Name of Cremation		80. Name of Disposition	
81. Name of Reburial		82. Name of Exhumation		83. Name of Removal		84. Name of Transfer	
85. Name of Relocation		86. Name of Disposal		87. Name of Burial		88. Name of Interment	
89. Name of Burial		90. Name of Interment		91. Name of Cremation		92. Name of Disposition	
93. Name of Reburial		94. Name of Exhumation		95. Name of Removal		96. Name of Transfer	
97. Name of Relocation		98. Name of Disposal		99. Name of Burial		100. Name of Interment	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3702

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank Chatmond

2. DATE  
OF  
DEATH

4-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

923 Brevard Street

c. Length of stay in Baltimore

50 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

?

9. AGE (In years  
last birthday)

79?

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Chatmond

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-09-0754

17. INFORMANT

ADDRESS

4940

Records\* Balto. City Hospitals Eastern Ave

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-4, 19 50 to 4-17, 19 50 that I last saw the  
deceased alive on 4-17, 19 50, and that death occurred at 11:10 P. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

4-19-1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary cemetery

24D. LOCATION (City, town, or county)

A. A. County

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Rev. J. A. Gibson Jr.

ADDRESS

1735 Druid Hill Ave.  
Balt. 17, Maryland



CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Funeral Home	
13. Name of Coroner		14. Name of Medical Examiner		15. Name of Pathologist		16. Name of Anatomist	
17. Name of Registrar		18. Name of Clerk		19. Name of Nurse		20. Name of Embalmer	
21. Name of Burial Place		22. Name of Funeral Home		23. Name of Coroner		24. Name of Medical Examiner	
25. Name of Pathologist		26. Name of Anatomist		27. Name of Registrar		28. Name of Clerk	
29. Name of Nurse		30. Name of Embalmer		31. Name of Burial Place		32. Name of Funeral Home	
33. Name of Coroner		34. Name of Medical Examiner		35. Name of Pathologist		36. Name of Anatomist	
37. Name of Registrar		38. Name of Clerk		39. Name of Nurse		40. Name of Embalmer	
41. Name of Burial Place		42. Name of Funeral Home		43. Name of Coroner		44. Name of Medical Examiner	
45. Name of Pathologist		46. Name of Anatomist		47. Name of Registrar		48. Name of Clerk	
49. Name of Nurse		50. Name of Embalmer		51. Name of Burial Place		52. Name of Funeral Home	
53. Name of Coroner		54. Name of Medical Examiner		55. Name of Pathologist		56. Name of Anatomist	
57. Name of Registrar		58. Name of Clerk		59. Name of Nurse		60. Name of Embalmer	
61. Name of Burial Place		62. Name of Funeral Home		63. Name of Coroner		64. Name of Medical Examiner	
65. Name of Pathologist		66. Name of Anatomist		67. Name of Registrar		68. Name of Clerk	
69. Name of Nurse		70. Name of Embalmer		71. Name of Burial Place		72. Name of Funeral Home	
73. Name of Coroner		74. Name of Medical Examiner		75. Name of Pathologist		76. Name of Anatomist	
77. Name of Registrar		78. Name of Clerk		79. Name of Nurse		80. Name of Embalmer	
81. Name of Burial Place		82. Name of Funeral Home		83. Name of Coroner		84. Name of Medical Examiner	
85. Name of Pathologist		86. Name of Anatomist		87. Name of Registrar		88. Name of Clerk	
89. Name of Nurse		90. Name of Embalmer		91. Name of Burial Place		92. Name of Funeral Home	
93. Name of Coroner		94. Name of Medical Examiner		95. Name of Pathologist		96. Name of Anatomist	
97. Name of Registrar		98. Name of Clerk		99. Name of Nurse		100. Name of Embalmer	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3703

Registered No. 1950

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary F. Bowling

2. DATE  
OF  
DEATH

April 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hosp.

c. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Balt.

12-05

D. STREET ADDRESS (If rural, give location)

2006 Maryland Ave.

8. DATE OF BIRTH

9-2-1885

9. AGE (in years last birthday)

77

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alek Justice

14. MOTHER'S MAIDEN NAME

Nancy Schwartz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Reas. S. Bowling 2117 ADDRESS

18. 4/20/50

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Coronary sclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 hr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-20-50 to 4-20-50, that I last saw the deceased alive on 4-20-50, and that death occurred at 3:22 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Merrill F. Nelson

23B. ADDRESS

Union Trng.

23C. DATE SIGNED

4-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/24/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county)

Parkville Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. Cook Inc. 1217 St. Paul St.

ADDRESS

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE

JANUARY 1, 1911

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE

ALBANY:  
J.B. LEECH, JR.,  
PRINTERS.

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
JANUARY 1, 1911

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE

ALBANY: J.B. LEECH, JR., PRINTERS.

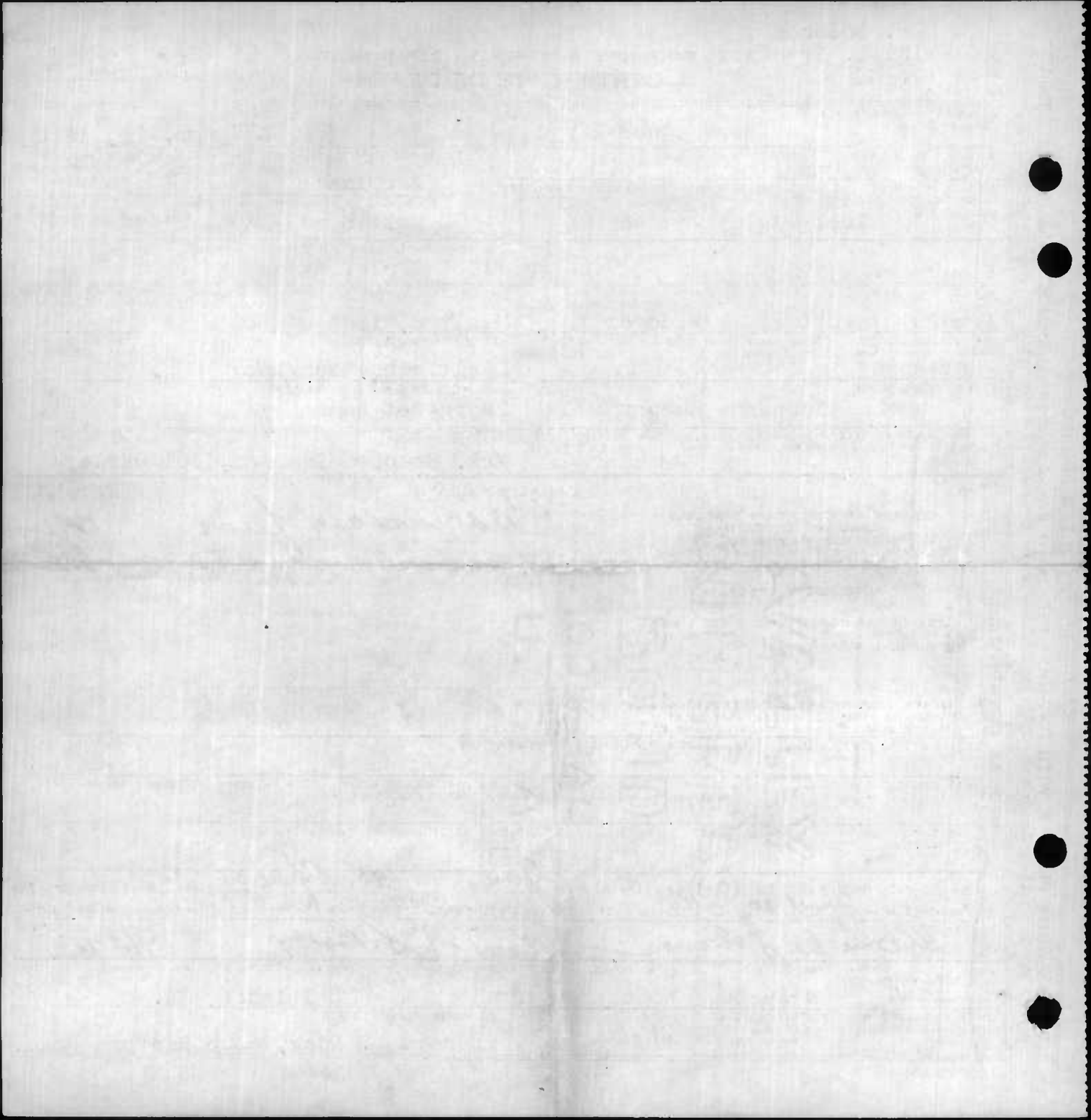
STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
JANUARY 1, 1911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Solomon  
129 S. Broadway BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3704

BIRTH NO. 50 3704		1. NAME OF DECEASED (Type or Print) Mary Agnes Lloyd		2. DATE OF DEATH Apr. 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1661 Darley Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-05			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1661 Darley Avenue			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 6, 1883	9. AGE (In years last birthday) 66	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Terrance Murphy		14. MOTHER'S MAIDEN NAME Margaret Hanson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Dolores Sampson, 1661 Darley	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I		CAUSE OF DEATH Carcinoma of Lung		INTERVAL BETWEEN ONSET AND DEATH 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
(B) DUE TO					
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 45, 1950, to April 21, 1950, that I last saw the deceased alive on April 20, 1950, and that death occurred at 2:30 a. m. from the causes and on the date stated above.					
23A. SIGNATURE Helen F. Solomon M. D.		23B. ADDRESS 129 S. Broadway		23C. DATE SIGNED 4/21/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 4-24-50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
DATE RECEIVED BY LOCAL REGISTRAR APR 21 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road.		ADDRESS	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3705

BIRTH NO. 524

1. NAME OF DECEASED (Type or Print) <u>Frederick Jacob Singler</u>		2. DATE OF DEATH <u>April 20 50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>6208 Lycamon Rd</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>Baltimore City</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>at home</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>27-12</u>	
c. Length of stay in Baltimore <u>Life</u>		D. STREET ADDRESS (If rural, give location) <u>6208 Lycamon Rd</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>June 11 1878</u>
9. AGE (In years last birthday) <u>71 yrs</u>	10. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Henry Singler</u>		14. MOTHER'S MAIDEN NAME <u>Louise Helweg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>J. Singler, Jr. (son)</u>		ADDRESS <u>Balto. Md.</u>	

18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u>	CAUSE OF DEATH (A) <u>Cerebral hemorrhage</u> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Hypertension + arteriosclerosis</u>	(B) <u>Hypertension + arteriosclerosis</u> DUE TO	<u>5 years +</u>
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>9</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>46</u> to <u>April 20</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>April 10</u> , 19 <u>50</u> , and that death occurred at <u>1230</u> pm., from the causes and on the date stated above.		
23A. SIGNATURE <u>Franklin E. Lohie</u> M. D.	23B. ADDRESS <u>1101 18 Paul St</u>	23C. DATE SIGNED <u>Apr. 21, 1950</u>

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Apr 22 50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Emid Ridge</u>	24D. LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>4-21-50</u>	REGISTRAR'S SIGNATURE <u>Huntington Williams</u>	25. FUNERAL DIRECTOR <u>Stewart &amp; Morrow Co.</u>	ADDRESS <u>Balto.</u>



STATE OF TEXAS  
COUNTY OF DALLAS  
CERTIFICATE OF DEATH

1. Name of deceased: *John Smith*  
2. Age: *45*  
3. Sex: *Male*  
4. Date of death: *Jan 15 1900*  
5. Place of death: *His home*  
6. Cause of death: *Heart disease*  
7. Name of physician: *Dr. J. H. Smith*  
8. Name of undertaker: *Wm. H. Smith*  
9. Name of witness: *John Smith*  
10. Name of witness: *John Smith*  
11. Name of witness: *John Smith*  
12. Name of witness: *John Smith*  
13. Name of witness: *John Smith*  
14. Name of witness: *John Smith*  
15. Name of witness: *John Smith*  
16. Name of witness: *John Smith*  
17. Name of witness: *John Smith*  
18. Name of witness: *John Smith*  
19. Name of witness: *John Smith*  
20. Name of witness: *John Smith*



T-500

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

50 3706  
 Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Effie Elizabeth Tomes		April 31-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
1615 Bolton		A. STATE Md- B. COUNTY Baltimore	
5. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
at home		Baltimore 14th	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
3 yrs.		1615 Bolton St	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Widowed	Oct 10/1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
none		none	57 yrs
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Linn - W. Va.		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Harrison		Elizabeth Radcliffe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
no		none	
17. INFORMANT		ADDRESS	
Orville G. Tomes		1615 Bolton	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			
(A) Carcinoma Rectum			2 1/2 years
DUE TO			
(B) Metastasis to Lung & Liver.			6 mos.
DUE TO			
(C)			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
1949		Ca Rectum - Colostomy.	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 31, 1950, to 21 April, 1950, that I last saw the deceased alive on 21 April, 1950, and that death occurred at 9:00 A.M., from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	
Laureston L. Brown M. D.		1938 Linden Ave	
23C. DATE SIGNED			
21 April 50			
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Apr-22/50	Linen Hill Cemetery	Linn W. Va.
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR ADDRESS	
		Shirley M. Morris Co. - Balto.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2/11/11

1. Name of deceased  
2. Age  
3. Sex  
4. Occupation  
5. Cause of death  
6. Date of death  
7. Place of death  
8. Name of informant  
9. Signature of informant  
10. Signature of doctor  
11. Signature of registrar

12. Date of registration  
13. Signature of registrar  
14. Signature of informant  
15. Signature of doctor  
16. Signature of registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

William B. Newman

2. DATE  
OF  
DEATH

4/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION)

2603 N. Charles St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Md.

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto,

12-06

D. STREET ADDRESS (If rural, give location)

2603 N. Charles St.

c. Length of stay in Baltimore

Lifetime

Yrs.  
Mcs.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 28 1869

9. AGE (In years,  
last birthday)

80

10. Under 1 Year  
Months Days

11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Union News Co.

11. BIRTHPLACE (State or foreign country)

Balto

12. CITIZEN OF  
U.S. COUNTRY?

U.S.

13. FATHER'S NAME

\*\*\*\*\*Newman

14. MOTHER'S MAIDEN NAME

\*\*\*\*\*Simpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

ADDRESS

Miss Evelyn Newman 2603 N. Charles St.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Generalized arteriosclerosis

?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Chronic degenerative heart

2 mos

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐

NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 30, 1950, to Apr 20, 1950, that I last saw the deceased alive on Apr 17, 1950, and that death occurred at 1:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Frederick Villmer M.D.

23B. ADDRESS

6100 York Rd

23C. DATE SIGNED

Apr 31, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/22/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cemetery

24D. LOCATION (City, town, or county)

Balto, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 21 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Charles H. Cranshaw, Inc.  
118 W. Mt. Royal Ave.

6100 York Rd.  
HO. 0136  
8973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3708  
Registered No. \_\_\_\_\_

50 3708  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>NORA MAE DIEHLMANN</b>		2. DATE OF DEATH <b>Apr 19, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>3115 Belvedere Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-17</b>	
c. Length of stay in Baltimore <b>40 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>3115 Belvedere Ave.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7/1/1882</b>
9. AGE (In years last birthday) <b>67</b>	10. UNDER 1 Year Months: Days	11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-9716B</b>	
17. INFORMANT <b>Ernest Diehlmann</b>		ADDRESS	
18. <b>410X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Aortic Stenosis</b> (A) <b>Mitral insufficiency</b> DUE TO <b>Rheumatic Heart Disease</b> (B) DUE TO (C) <b>Carcinoma Fundus uteri</b>		INTERVAL BETWEEN ONSET AND DEATH <b>13 years +</b> <b>Indefinite</b> <b>1 1/2 years +</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>April</b> , 19 <b>49</b> to <b>19 April</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>18 April</b> , 19 <b>50</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Thos. J. Smith</b>		23B. ADDRESS M. D. <b>1261 E. Belvedere Ave</b>	
23C. DATE SIGNED <b>20 April 50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/22/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 21 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Easton Sons</b>		ADDRESS <b>Catonsville, Md.</b>	







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

K-620

50 3709

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3709

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA KRIZ

2. DATE  
OF  
DEATH

4/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Maryland General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

HARFORD

C. CITY OR TOWN

Joppa

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

45 years

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

12-4-1881

9. AGE (In years last birthday)

68

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Hlavicka

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Husband (Matthew) as above

ADDRESS

18. 420 0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

INTERVAL BETWEEN ONSET AND DEATH

acute day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

(C) Hypertensive cardiovascular disease

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cholelithiasis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/20, 1950 to 4/20, 1950 that I last saw the deceased alive on 4/20, 1950 and that death occurred at 5:45 PM, from the causes and on the date stated above.

23A. SIGNATURE

Marymount Louisa Carder

23B. ADDRESS

Maryland General Hosp

23C. DATE SIGNED

4/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

Apr. 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Green Mount Cematory

24D. LOCATION (City, town, or county)

North Ave. & Oliver St. Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Schimmnek Funeral Home, Inc.

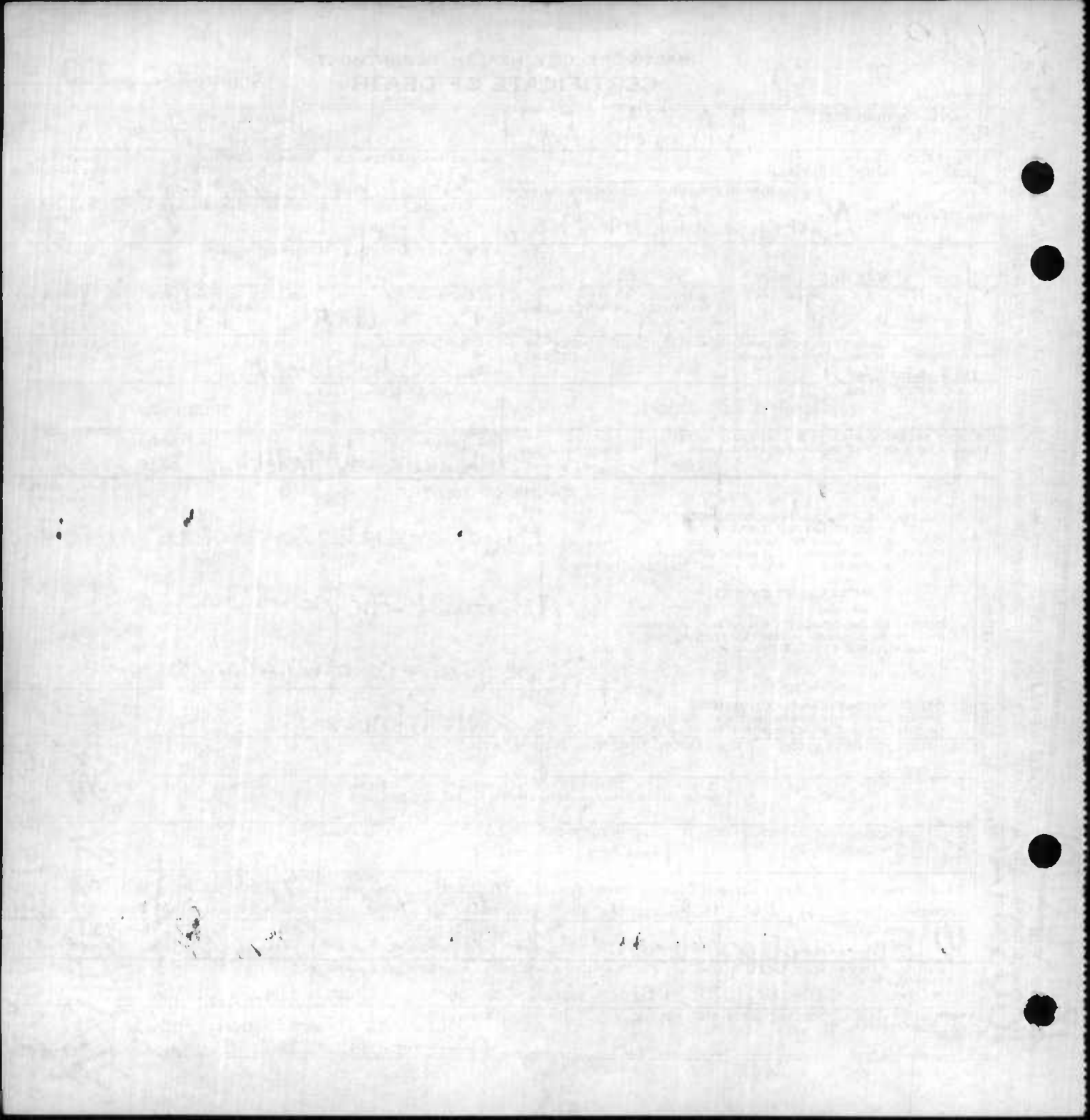
ADDRESS

2601-3-5 D, Madison St. Chas. B. Schimmnek

APR 24 1950

Washington Williams, M.D.

937 Pres.



USE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EISA BRUELL

2. DATE  
OF  
DEATH

4/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland *West Balt Gen'l Hosp.*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION location)

*West Balt Gen'l Hosp.*

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Baltimore 11

c. Length of stay in Baltimore

2 1/2 yrs

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3616 FOREST PARK AVE

5. SEX

FEMALE

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

MAR 19 1878

9. AGE (In years;  
last birthday)

72

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Austria

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Philip Adler

14. MOTHER'S MAIDEN NAME

Julia Signes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or up/down) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ave.

Mr. Frank Kauffman 3616 Forest Pk.

18.

E 916.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) 2°-3° BURNS OF ENTIRE BODY

4 hrs

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

Dr. Kammer  
per R. S. Fisher M. D.

CHIEF OF MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

ACCIDENT

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

None 3616 Forest Pk Ave

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Balt. Md 3616 Forest Pk Ave

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

4/20/50 5:50 P.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

FELL ASLEEP SMOKING CIGARETTE

22. I hereby certify that I attended the deceased from 4/20, 1950, to 4/20, 1950, that I last saw the  
deceased alive on 4/20, 1950, and that death occurred at 5:50 P.m., from the causes and on the date stated above.

23A. SIGNATURE

E. Robert Hardy

M. D.

23B. ADDRESS

West Balt. Gen'l Hosp

23C. DATE SIGNED

4/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Cremation

24B. DATE

April 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Louden Park.

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

David Sondheim

ADDRESS

4902 Eutaw Pl.

CERTIFICATE OF DEATH

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_

SEX: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

DATE OF INTERMENT: \_\_\_\_\_

PLACE OF INTERMENT: \_\_\_\_\_

SIGNATURE OF DECEASED: \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_

SIGNATURE OF MINISTER: \_\_\_\_\_

SIGNATURE OF CLERK: \_\_\_\_\_

SIGNATURE OF JUDGE: \_\_\_\_\_

SIGNATURE OF SHERIFF: \_\_\_\_\_

SIGNATURE OF CORONER: \_\_\_\_\_

SIGNATURE OF JURY: \_\_\_\_\_

SIGNATURE OF COURT: \_\_\_\_\_

SIGNATURE OF STATE: \_\_\_\_\_

SIGNATURE OF COUNTY: \_\_\_\_\_

SIGNATURE OF CITY: \_\_\_\_\_

SIGNATURE OF TOWN: \_\_\_\_\_

SIGNATURE OF VILLAGE: \_\_\_\_\_

SIGNATURE OF POST OFFICE: \_\_\_\_\_

SIGNATURE OF SCHOOL: \_\_\_\_\_

SIGNATURE OF CHURCH: \_\_\_\_\_

SIGNATURE OF SYNAGOGUE: \_\_\_\_\_

SIGNATURE OF MOSQUE: \_\_\_\_\_

SIGNATURE OF TEMPLE: \_\_\_\_\_

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3711

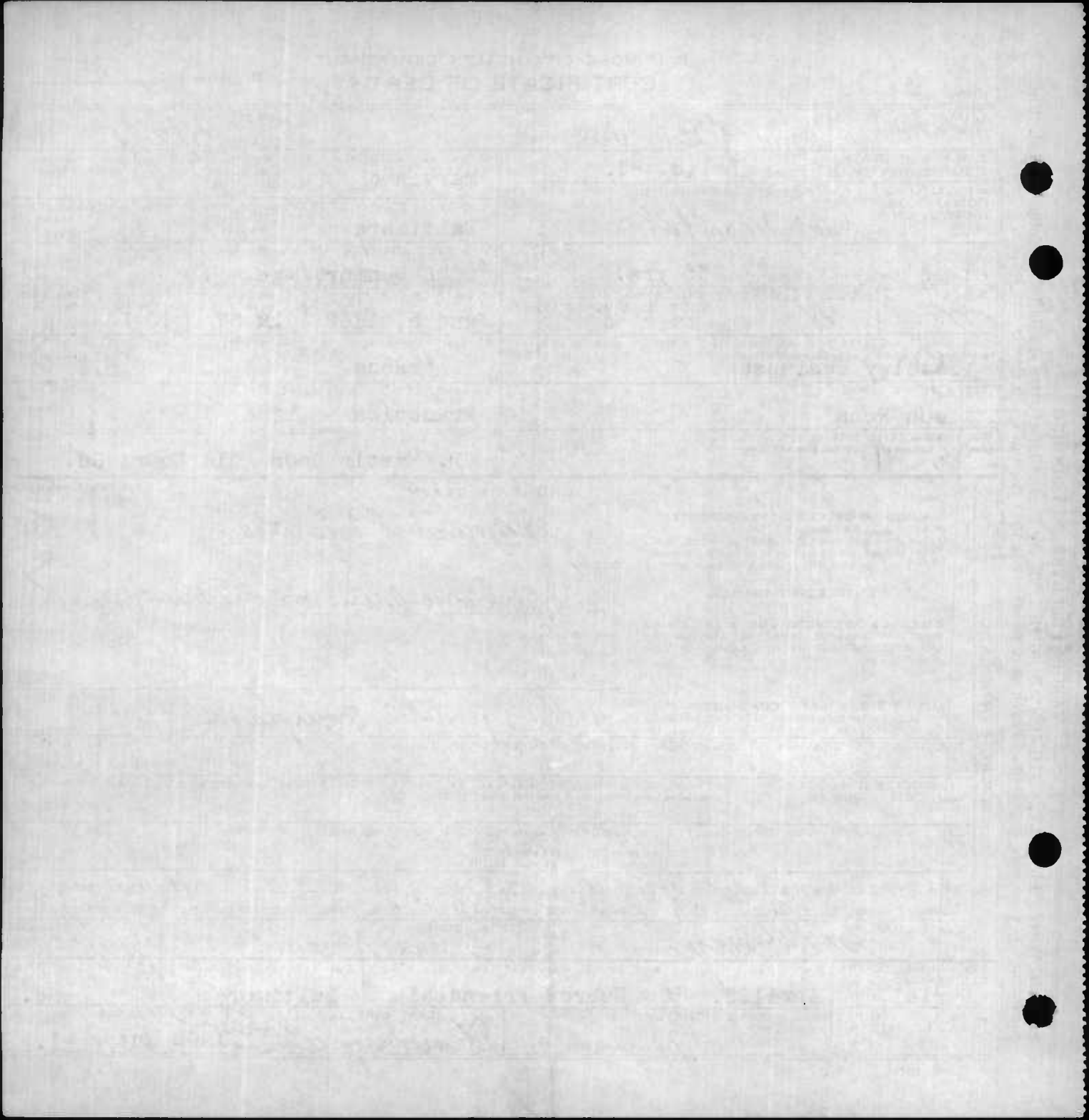
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Samuel B. Roos</i>			2. DATE OF DEATH <i>4/21/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Md.</i>			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>27-18</i>		
c. Length of stay in Baltimore <i>65 yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>5006 Denmore Ave.</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>June 5, 1862</i>		9. AGE (In years last birthday) <i>10 87</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Jewelry Business</i>			11. BIRTHPLACE (State or foreign country) <i>France</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Leon Roos</i>			14. MOTHER'S MAIDEN NAME <i>Francoise ?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mr. Martin Roos Old Court Rd.</i>		

18. <i>420.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>myocardial infarction</i> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Beriberi</i> <i>Hyperkensive Arteriosclerotic Heart Disease.</i> DUE TO					
19A. DATE OF OPERATION <i>0</i>			19B. MAJOR FINDINGS OF OPERATION <i>Beriberi</i>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/9</i> 19 <i>50</i> , to <i>4/21</i> 19 <i>50</i> , that I last saw the deceased alive on <i>4/21</i> 19 <i>50</i> , and that death occurred at <i>1st</i> A. M., from the causes and on the date stated above.					
23A. SIGNATURE <i>M. Rodereze</i>		23B. ADDRESS <i>Sinai Hospital</i>		23C. DATE SIGNED <i>4/21/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>April 23, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Hebrew Friendship</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. LOCATION (City, town, or county) <i>Baltimore</i>		24F. LOCATION (City, town, or county) <i>Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 21 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>David S. Condon</i>	
ADDRESS <i>1902 Eutaw Pl.</i>					







M-500

MAUN

50 3712

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Andrew Strite Maun

2. DATE  
OF  
DEATH

4/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 607 E. Biddle St.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

DO

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

CITY OR TOWN

Md

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

10-01

D. STREET ADDRESS (If rural, give location)

607 E Biddle St

c. Length of stay in Baltimore

27

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

male

white

married

4/4/1879

71

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

Machinist

General Machin Shop

Franklin Co. Pa

U.S.A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Leland Maun

Margaret Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

No

212-01-1145

Charles J Maun 927 ARCON VILL

18. 4200

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Thrombosis

28 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from March 26, 1950 to April 22, 1950 that I last saw the  
deceased alive on 22nd, 1950, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Dr. J. F. Zimmerman M.D.

2858 Harwood Rd

4-22-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4/25/50

Green Hill Cemetery

Waynesboro

Pa.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 22 1950

Wilmington Williams, M.

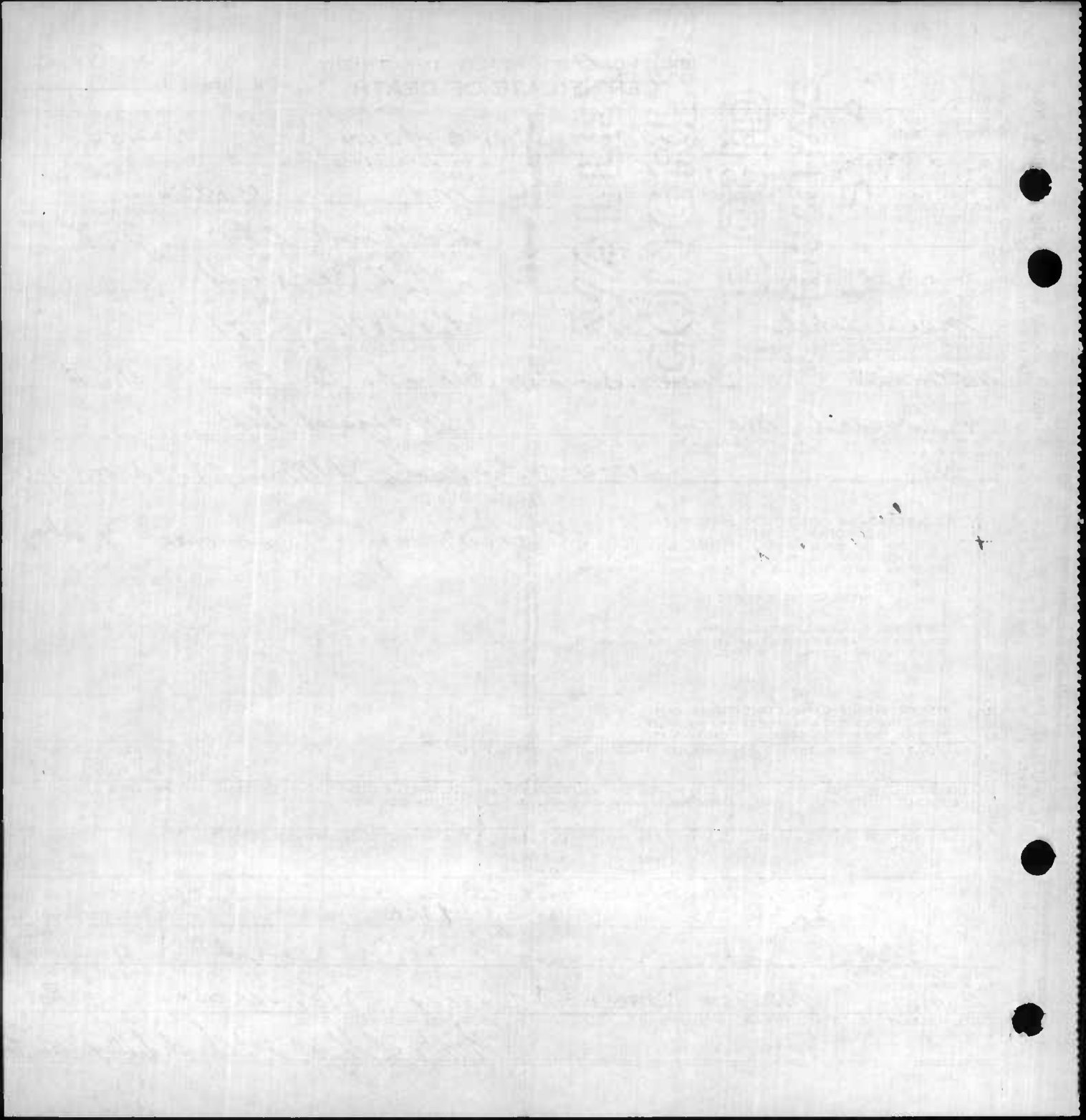
Walter J. Hume 271 Church St. Waynesboro, Pa.

VS 150

326 37

94a

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3713

Registered No. \_\_\_\_\_

50 3713  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Robert M. O'NEALE</b>			2. DATE OF DEATH <b>April 21, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Cecil</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pinecrest Sanatorium</b> <b>600 S. Chapel St. &amp; Ln.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Annapolis</b> <b>5210</b>		
c. Length of stay in Baltimore <b>2</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>us Brewer Ave.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 7, 1864</b>		9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chf. R.P.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Oliver B. O'Meara Annapolis, MD</b>	

<p>18. <b>422.1</b></p> <p><b>I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>CAUSE OF DEATH</b> <b>CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION</b></p> <p><b>ANTECEDENT CAUSES</b> <b>Generalized Arteriosclerosis</b></p> <p><b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b></p> <p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>	<p><b>CAUSE OF DEATH</b> <b>CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION</b></p> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>YEARS</b></p> <p><b>Generalized Arteriosclerosis</b></p>	<p><b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>YEARS</b></p>
	<p><b>ANTECEDENT CAUSES</b> <b>Generalized Arteriosclerosis</b></p>	
	<p><b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b></p>	
	<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>February 28, 1950</b> , to <b>April 21, 1950</b> , that I last saw the deceased alive on <b>April 21, 1950</b> , and that death occurred at <b>5:14 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Melvin N. Brenden</b>		23B. ADDRESS <b>2030 W. Fayette St</b>		23C. DATE SIGNED <b>4/21/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baldwin Memorial</b>	
24D. LOCATION (City, town, or county) (State) <b>Millersville, Md.</b>		25. FUNERAL DIRECTOR <b>B. J. Hopping &amp; Son</b>		ADDRESS <b>Annapolis, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 22 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md.</b>			

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF TEXAS  
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary Public in and for the State of Texas

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3714  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARY E. GLASS

2. DATE  
OF  
DEATH April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1418 N. Bond St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland  
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 8-07

D. STREET ADDRESS (If rural, give location)  
1418 N. Bond St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

July 1, 1861

9. AGE (In years  
last birthday)

88

10 Under 1 Year  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Peter White

14. MOTHER'S MAIDEN NAME

Margaret Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Mr Robert Glass, 1418 N. Bond St

18. 157X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Adeno Carcinoma of Neck  
of Pancreas.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

Feb 1950

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February, 1950, to April 21, 1950; that I last saw the deceased alive on April 17, 1950, and that death occurred at 6 A. M., from the causes and on the date stated above.

23A. SIGNATURE

James E. White

23B. ADDRESS

5214 Hayford Rd

23C. DATE SIGNED

21 April 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/24.50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county) (State)

Baltimore County, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

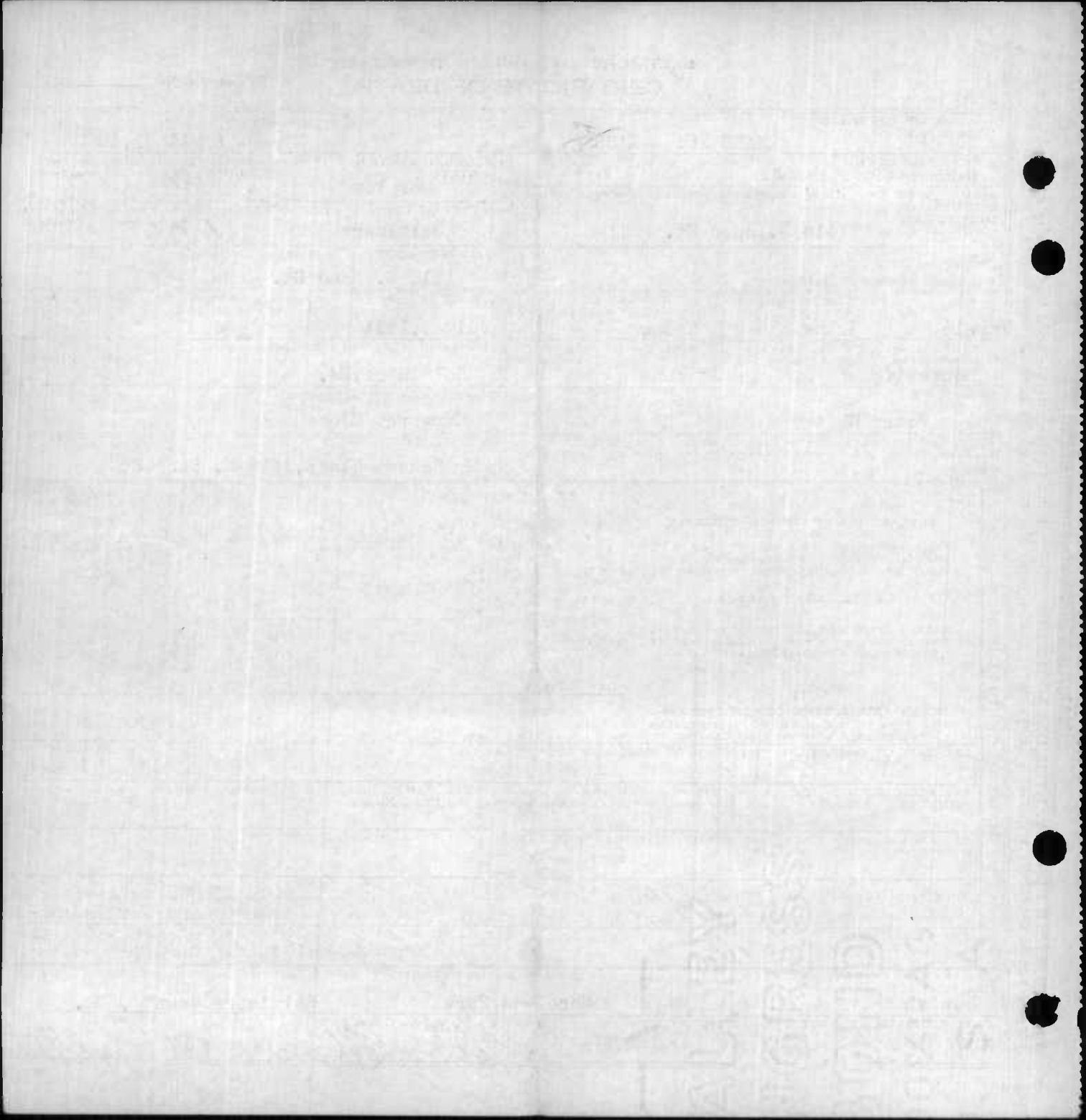
APR 22 1950

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

William G. G. 1217 St Paul St





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

530

CERTIFICATE CORRECTED 4-27-50

50 3715

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3715  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Albert L. Schmidt		4/21/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Glen Burnie	
C. Length of stay in Baltimore 1 yr. 1 mo. 1 day		D. STREET ADDRESS (If rural, give location) 405 Delmar Avenue 5200	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1-21-1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipyard worker		11. BIRTHPLACE (State or foreign country) Md.	
10B. KIND OF BUSINESS OR INDUSTRY ship fitter		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Schmidt		14. MOTHER'S MAIDEN NAME Fannie Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) _____	17. INFORMANT Anna B. Schmidt-405 Delmar Ave. Annapolis Md.	

18. <u>443X</u>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) <u>Cerebrovascular Accident</u>		<u>48 hrs</u>
	DUE TO		
	(B) <u>Hypertensive cardiovascular disease</u>		
DUE TO			
(C)			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4 - 19, 1950</u> , to <u>4 - 21, 1950</u> , that I last saw the deceased alive on <u>4/20</u> , 19 <u>50</u> , and that death occurred at <u>2:15</u> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Myrte Louise Cardle</u>		23B. ADDRESS <u>Md. General Hospital</u>		23C. DATE SIGNED <u>4/21/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/24/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 22 1950</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams</u>		25. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook Inc. 1217 St. Paul St.</u>	

UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3716  
Registered No.

BIRTH NO. 50 3716

1. NAME OF DECEASED  
(Type or Print)

GLADYS C. Gosnell

2. DATE

OF

DEATH

April 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

00 3624 Elkader Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3624 Elkader Road

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 20, 1899

9. AGE (In years last birthday)

50

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles T. Richardson

14. MOTHER'S MAIDEN NAME

Clara Sipple

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Mr Horace E. Gosnell, 3624 Elkader Road.

18.

203 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Myeloma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

Approx. 1 1/2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 28, 1950 to April 20, 1950, that I last saw the deceased alive on April 18, 1950, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles V. Sweeney, M. D.

23B. ADDRESS

3601 Adria Ave

23C. DATE SIGNED

4/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/24/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Park

24D. LOCATION (City, town, or county) (State)

Baltimore County, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Theodore C. Cline, 1217 St Paul St

VS 150

55E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTITUTE OF DEATH

DEATH CERTIFICATE

NO. 1000

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-655

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3717

Registered No. \_\_\_\_\_

50 3717 JL - 135009

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Anna Tranem</b>		2. DATE OF DEATH <b>4-21-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>11-01</b>			
c. Length of stay in Baltimore <b>?</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>721 St. Paul St.</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Sep.</b>		8. DATE OF BIRTH <b>Jan. 19, 1907</b>	9. AGE (In years last birthday) <b>43</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John Cox</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>B. C. H. 4940 Eastern Ave.</b>	
18. <b>002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1-16-50</b> , 19 <b>50</b> , to <b>April 21, 1950</b> , that I last saw the deceased alive on <b>April 21, 1950</b> and that death occurred at <b>9.45AM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i> M. D.		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>4-21-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>April 24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>	
24D. LOCATION (City, town, or county) (State) <b>Hamden</b>		DATE RECEIVED BY LOCAL REGISTRAR <b>APR 22 1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
25. FUNERAL DIRECTOR <b>Chas. F. Dies</b>		ADDRESS <b>1201 C. Fort Ave.</b>			

1/10  
W. A. W.  
C. W. W.

W. A. W.  
C. W. W.

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C. W. W.

W. A. W.  
C. W. W.

W. A. W.  
C. W. W.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3718

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY A. EHART

2. DATE  
OF  
DEATH

4/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

100 W. COLD SPRING LANE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 25-04

60

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

208 WASHBURN AVE.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

FEBR. 2 - 1869

9. AGE (In years last birthday)

81

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE WORK

10B. KIND OF BUSINESS OR INDUSTRY

CHURCH RECTORY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ANSELM EHART

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypostatic pneumonia

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerotic cardiovascular disease

DUE TO

(C) (Similar)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1949, to 7/21, 1950, that I last saw the deceased alive on 4/18, 1950, and that death occurred at 9:00 Am., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

APRIL 24-50

HOLY CROSS CEMETERY

A.A.CO. MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 22 1950

Wm. J. Williams, M.D.

Elizabeth Harb Inc. 115 E. WEST ST.

STATE OF TEXAS  
COUNTY OF DALLAS

WITNESSES

NOTARY PUBLIC

STATE OF TEXAS

COUNTY OF DALLAS

NOTARY PUBLIC

NOTARY PUBLIC

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NOTARY PUBLIC

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**CERTIFICATE CORRECTED**

4-27-50

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3719

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>FLORENCE G. PFEIFER</b>			2. DATE OF DEATH <b>4/20/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-19</b>		
c. Length of stay in Baltimore <b>life</b>			D. STREET ADDRESS (If rural, give location) <b>2806 West Rogers Ave #15</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1884</b> <b>Aug. 30, 1884</b>		9. AGE (In years last birthday) <b>65 68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Dolan</b>			14. MOTHER'S MAIDEN NAME <b>Mary Maloney</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	17. INFORMANT ADDRESS <b>Daughter Mrs Shipley as above</b>		

18. <b>443 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>H.C.V.D.</b>	CAUSE OF DEATH <b>CONGESTIVE HEART FAILURE</b> <b>H.C.V.D.</b> <b>myxedema</b>	INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3-19, 1950</b> to <b>4-20, 1950</b> that I last saw the deceased alive on <b>4/20, 1950</b> and that death occurred at <b>7:08 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Marguerite Louise Cadley</b> M. D.		23B. ADDRESS <b>Maryland General Hosp</b>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/24/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Tickenner &amp; Sons - Balto Md.</b>		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 22 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Tickenner</b>		ADDRESS	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

Cause of Death

Signature of Physician

Signature of Registrar

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3720

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY F. ROSENDALE, Sr.

2. DATE  
OF  
DEATH

Apr. 21-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

27-02

D. STREET ADDRESS (If rural, give location)

2806 Montebello Terrace

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Apr. 25-1873

9. AGE (In years last birthday)

76

10. Under 1 Year  
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Furniture Salesman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Christopher Rosendale

14. MOTHER'S MAIDEN NAME

Margaret Rosemer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret Rosendale- 2806 Montebello Terrace

18. 150X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of the Esophagus

4 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Constriction of the Esophagus

?

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4-20, 1950, to 4-21, 1950, that I last saw the deceased alive on 4-21, 1950, and that death occurred at 6:00 P. M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Holloway

M. D.

23B. ADDRESS

Redwood &amp; Greene Sts

23C. DATE SIGNED

4-21-50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4/25/50

New Cathedral

Balto Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

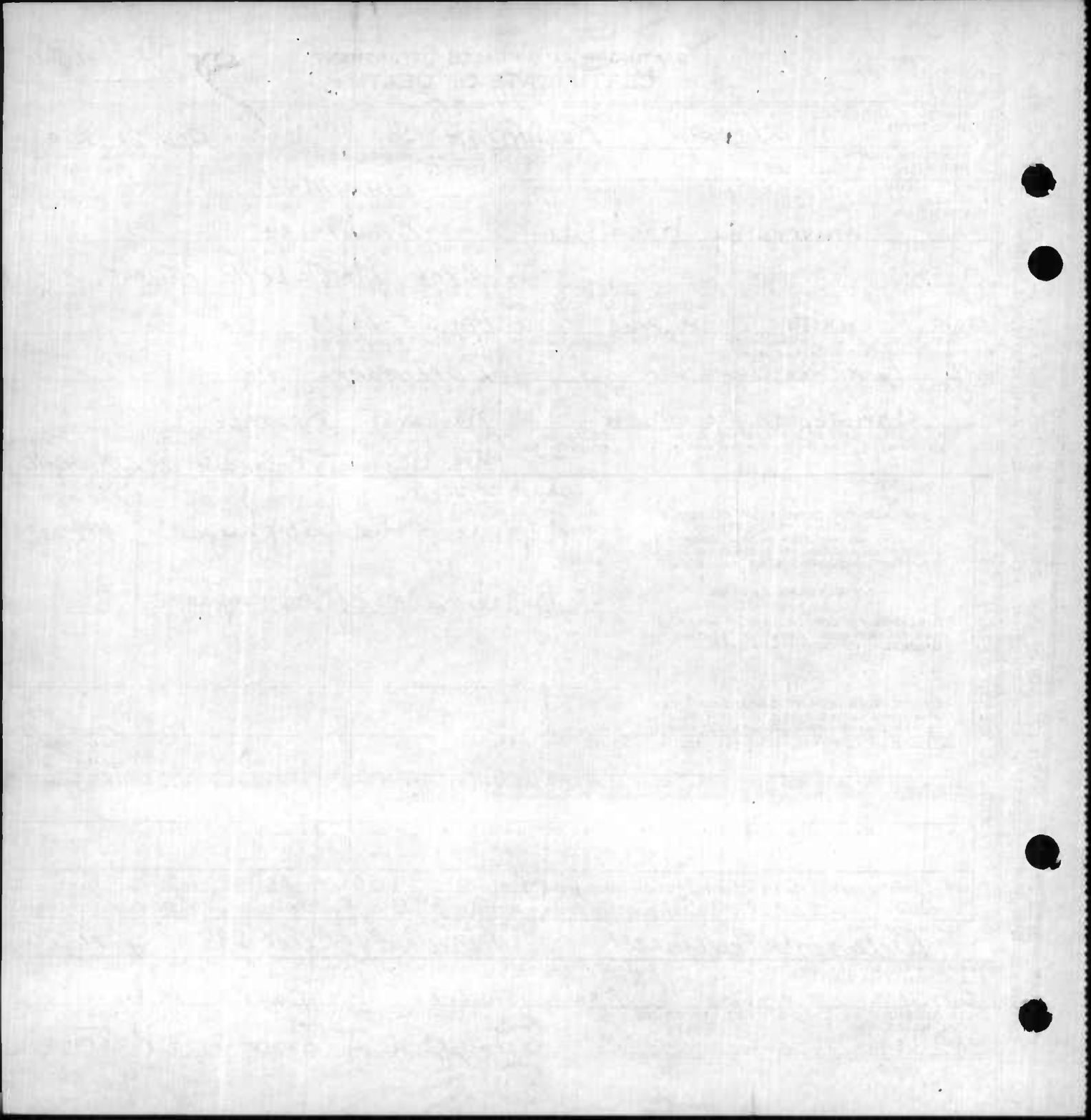
ADDRESS

APR 22 1950

William J. Holloway, M.D.

Leonard J. Ruck- 5305 Hartford







7-452  
Dr. Golley

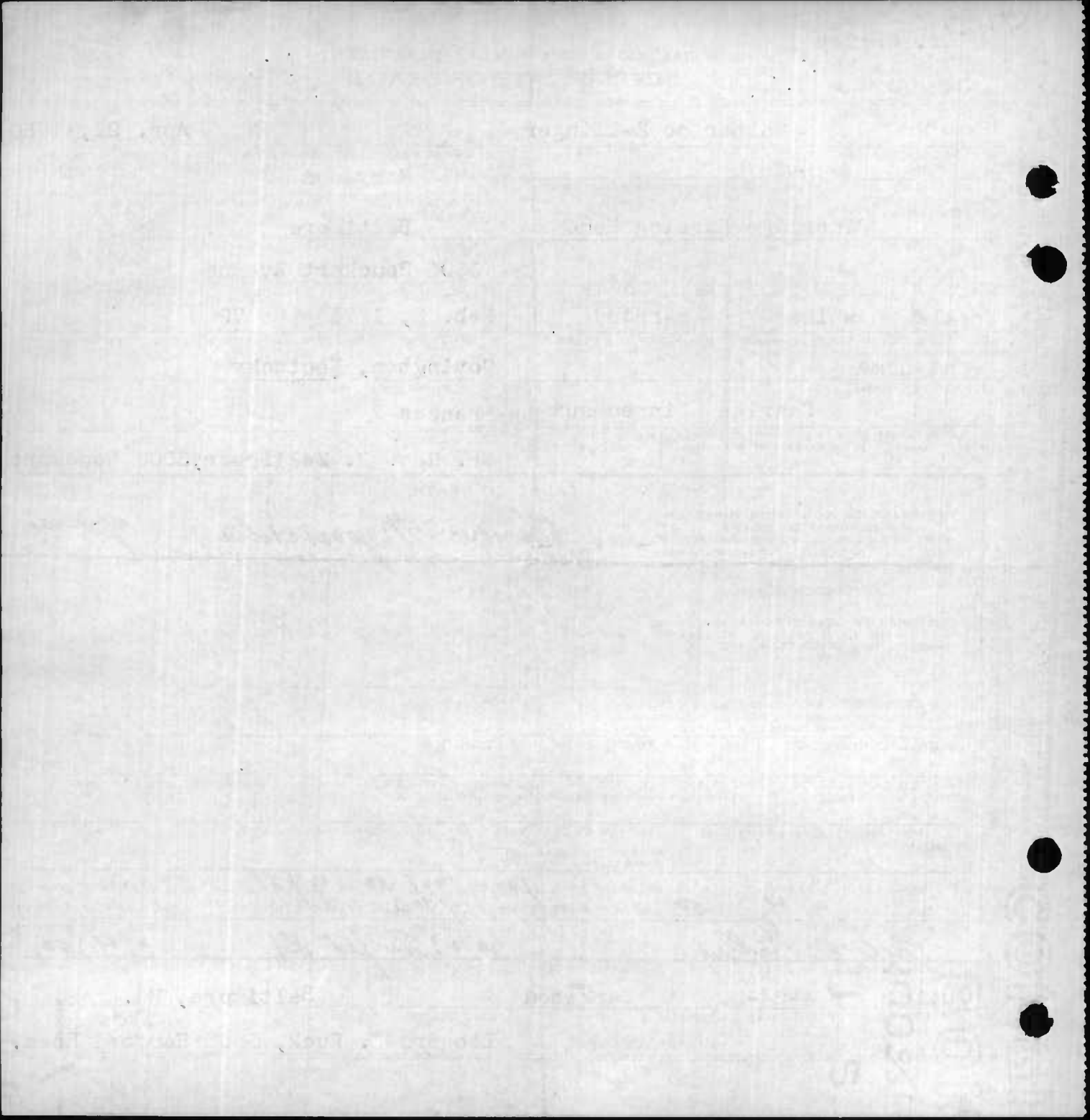
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3721  
Registered No.

BIRTH NO. 50 3721

1. NAME OF DECEASED (Type or Print) Catherine Zellinger			2. DATE OF DEATH Apr. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Pineridge Nursing Home			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-03		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 3008 Reuckert Avenue		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 2, 1871		9. AGE (in years, last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Covington, Kentucky		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Linnenbaum			14. MOTHER'S MAIDEN NAME Frances ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Geo. N. Zellinger, 3008 Reuckert		

18. 4-22-50 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic Myocarditis			INTERVAL BETWEEN ONSET AND DEATH years		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1947, 1950, to 4/21, 1950, that I last saw the deceased alive on 4/21, 1950, and that death occurred at 9:30 a.m., from the causes and on the date stated above.					
23A. SIGNATURE H. W. Golley		23B. ADDRESS M. D. 5103 Harford Rd		23C. DATE SIGNED 4/24/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-24-50	24C. NAME OF CEMETERY OR CREMATORY Parkwood	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
DATE RECEIVED BY LOCAL REGISTRAR APR 22 1950		REGISTRAR'S SIGNATURE William Williams	25. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, 5305 Harford Road.		



K-400

50 3722

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3722  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER S. Kelly

2. DATE  
OF  
DEATH

April 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balt. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

48 MARYLAND GEN. HOSP

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rock Hall

c. Length of stay in Baltimore

57 yrs.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 10, 1892

9. AGE (In years last birthday)

57

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

154X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

4/8/50

19B. MAJOR FINDINGS OF OPERATION

Ca of Rectum with metastasis to Liver

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8/50, to 4/22, 1950, that I last saw the deceased alive on 4/22, 1950, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Arthur C. Verone

23B. ADDRESS

Maryland Gen. Hosp

23C. DATE SIGNED

4/22/50

24A. (BURIAL) CREMA-  
TION, REMOVAL (Specify)

24B. DATE

April 26-50

24C. NAME OF CEMETERY OR CREMATORY

Wesley Chapel

24D. LOCATION (City, town, or county)

Rock Hall Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Edgar L Lane Church Hill Md

APR 23 1950

000VV

467

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



G-416  
50 3723BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3723

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY R. GILBERT

2. DATE  
OF  
DEATH

4/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

43 South Baltimore General Hosp.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Dundalk

c. Length of stay in Baltimore

14

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

6820 Belclare Road

5300

5. SEX

M.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

S.

8. DATE OF BIRTH

Nov. 26, 1914

9. AGE (In years  
last birthday)

35

If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.12. CITIZEN OF  
WHAT COUNTRY?10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Steel Worker

10B. KIND OF BUSINESS OR  
INDUSTRY

Beth. Steel Co.

11. BIRTHPLACE (State or foreign country)

Virginia

13. FATHER'S NAME

Emmett R. Gilbert

14. MOTHER'S MAIDEN NAME

Josie R. Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Josie R. Gilbert, Clifton Forge, Va.

18. 331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cerebral hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Essential hypertension

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21/50 to 4/21/50, that I last saw the  
deceased alive on 4/21/50, and that death occurred at p. m., from the causes and on the date stated above.

23A. SIGNATURE

Ray D. Ferguson M. D.

23B. ADDRESS

1213 Light St.

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 23 1950

R. L. Williams

Roland L. Fisher, 2112 Dundalk Ave.

VS 150

49629

83a

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Cause of Death		Manner of Death	
Occupation		Residence	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	





C-651  
50 3724BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3724  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Morris Chernoff

2. DATE  
OF  
DEATH

April 22, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Ind.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-10

D. STREET ADDRESS (If rural, give location)

3301 Oakfield Ave

c. Length of stay in Baltimore

10 Yrs.  
Moe-  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 14, 1904

9. AGE (In years  
1st birthday)

45 1/2 yrs

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

Records

18. 416X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial infarction

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

12 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Rheumatic heart disease

DUE TO

7 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from April 20, 1950 to April 22, 1950, that I last saw the  
deceased alive on April 22, 1950 and that death occurred at 3:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

J. C. Sandell, Jr.

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4-22-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

New York

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis 2100 Eutan Rd



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3725  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hannah G. McAuliffe

2. DATE  
OF  
DEATH April 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 407 Southway

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Baltimore B. COUNTY Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION location)

Guilford

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 12-02

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

407 Southway, Guilford

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

About

9. AGE (In years last birthday)

85

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John McAuliffe

14. MOTHER'S MAIDEN NAME

Honora Galway

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Mrs. Marie D. Thomas 407 Southway

18. 4500

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) general arteriosclerosis  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 6, 1950 to Apr 22, 1950 that I last saw the deceased alive on Apr 11, 1950 and that death occurred at 1 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. J. Schmitz

M. D.

23B. ADDRESS

701 N. Kenwood Ave

23C. DATE SIGNED

7/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/24/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

H.W. Measwell

ADDRESS

805 N. Calvert

APR 23 1950

VS 150

97

st

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3726  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

<sup>MILLER</sup>  
Noahlene May

2. DATE  
OF  
DEATH

Apr-21-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 301 Woodlawn Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore City

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City 22-14

C. Length of stay in Baltimore

Life

O. STREET ADDRESS (If rural, give location)

301 Woodlawn Road

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Nov-25-1878

9. AGE (In years last birthday)

71

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mayhew May

14. MOTHER'S MAIDEN NAME

Ruth S. Shumway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

None

None

16. SOCIAL SECURITY NO.

None

17. INFORMATION ADDRESS

JOHN HOPKINS HOSPITAL Mrs. Richard F. Horne (daughter) Balto, Md.

18. 260 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Acute pulmonary edema  
DUE TO Congestive heart failure  
(B) Diabetes mellitus

DUE TO

Hypertension  
or Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

48 hours  
2+ years  
27 years  
2 years.

19A. DATE OF OPERATION 2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from —, 1937, to 21 April, 1950, that I last saw the deceased alive on 20 April, 1950, and that death occurred at 10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John P. Lamberson Jr.

23B. ADDRESS

JOHN HOPKINS HOSPITAL 1207 Eutaw Place

23C. DATE SIGNED

21 April 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Apr-24-1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 23 1950

REGISTRAR'S SIGNATURE

Christington Williams, M.D.

25. FUNERAL DIRECTOR

Stewart & Morison Co., 108 W. North Ave.

ADDRESS

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

January 1, 1910

Albany

Dr. J. C. Smith  
New York

Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the above named case.

I am sorry to hear of the death of the patient, and regret that I was unable to see the case in person. The case is being investigated by the local health authorities, and I am sure that the results will be made known to you in due season.



B-260

50 3727

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3727  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Nicholas Beser</i>		2. DATE OF DEATH <i>April 22, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-11</i>			
c. Length of stay in Baltimore <i>31 Yrs</i>		D. STREET ADDRESS (If rural, give location) <i>3510 Copley Road</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>May 1, 1889</i>	9. AGE (In years last birthday) <i>60</i>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Business</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own</i>	11. BIRTHPLACE (State or foreign country) <i>Cincinnati Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
13. FATHER'S NAME <i>Louis Beser</i>			14. MOTHER'S MAIDEN NAME <i>Sonia ?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes W. W. I</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Rose Beser 3510 Copley Road</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Acute Myocardial Infarction 2d</i> DUE TO (B) <i>Arteriosclerotic Coronary 2d</i> DUE TO <i>Occlusion</i> (C) <i>Diabetes Mellitus</i>	INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>
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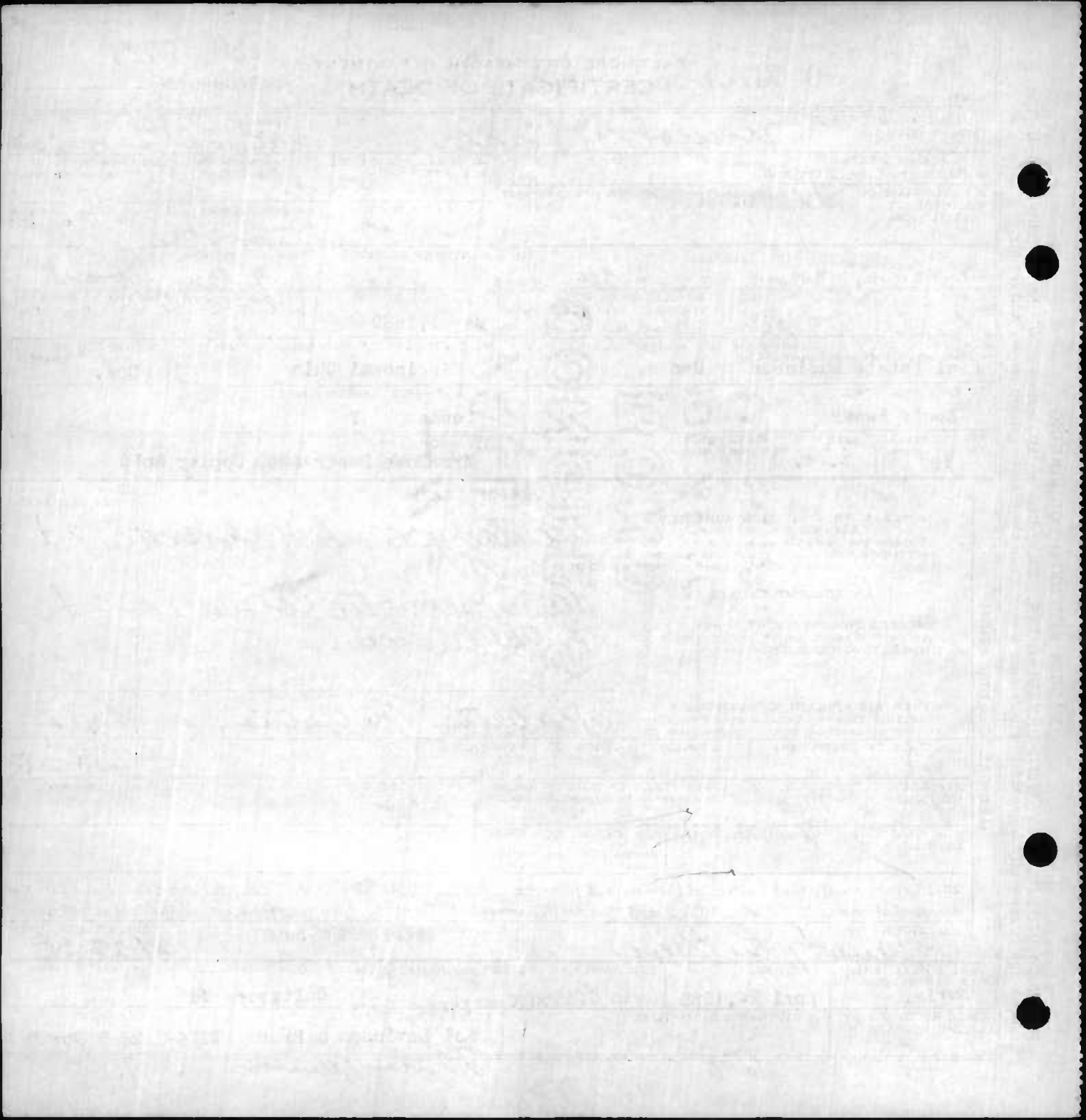
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-22-</i> , 19 <i>50</i> to <i>4-22-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>4-22</i> , 19 <i>50</i> , and that death occurred at <i>12:40</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Louis Beser</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>4-22-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>April 24, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Beth Tfiloh Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson &amp; Bros 1124-1126 W North A</i>			

APR 30 1950

27681

61

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3728

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bessie Goldstein

2. DATE  
OF  
DEATH

April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE

Maryland

B. COUNTY

before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

60 Mt. Nursing Home, (Norton Road)

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2104 Presbury Street

c. Length of stay in Baltimore

50 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

1884

9. AGE (In years,  
last birthday)

66

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Hyman Wolf Kushner

14. MOTHER'S MAIDEN NAME

?????

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Aaron I. Goldstein 307 W. 79th St N. Y.

ADDRESS N. Y.  
N. Y.

18.

163X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Lungs

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 15, 1950, to April 21, 1950, that I last saw the deceased alive on April 21, 1950, and that death occurred at 1:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Abraham Schapira MD

23B. ADDRESS

2028 Eutaw Place

23C. DATE SIGNED

4-22-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-23-50

24C. NAME OF CEMETERY OR CREMATORY

Aitz Chaim Congregation

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams MD

25. FUNERAL DIRECTOR

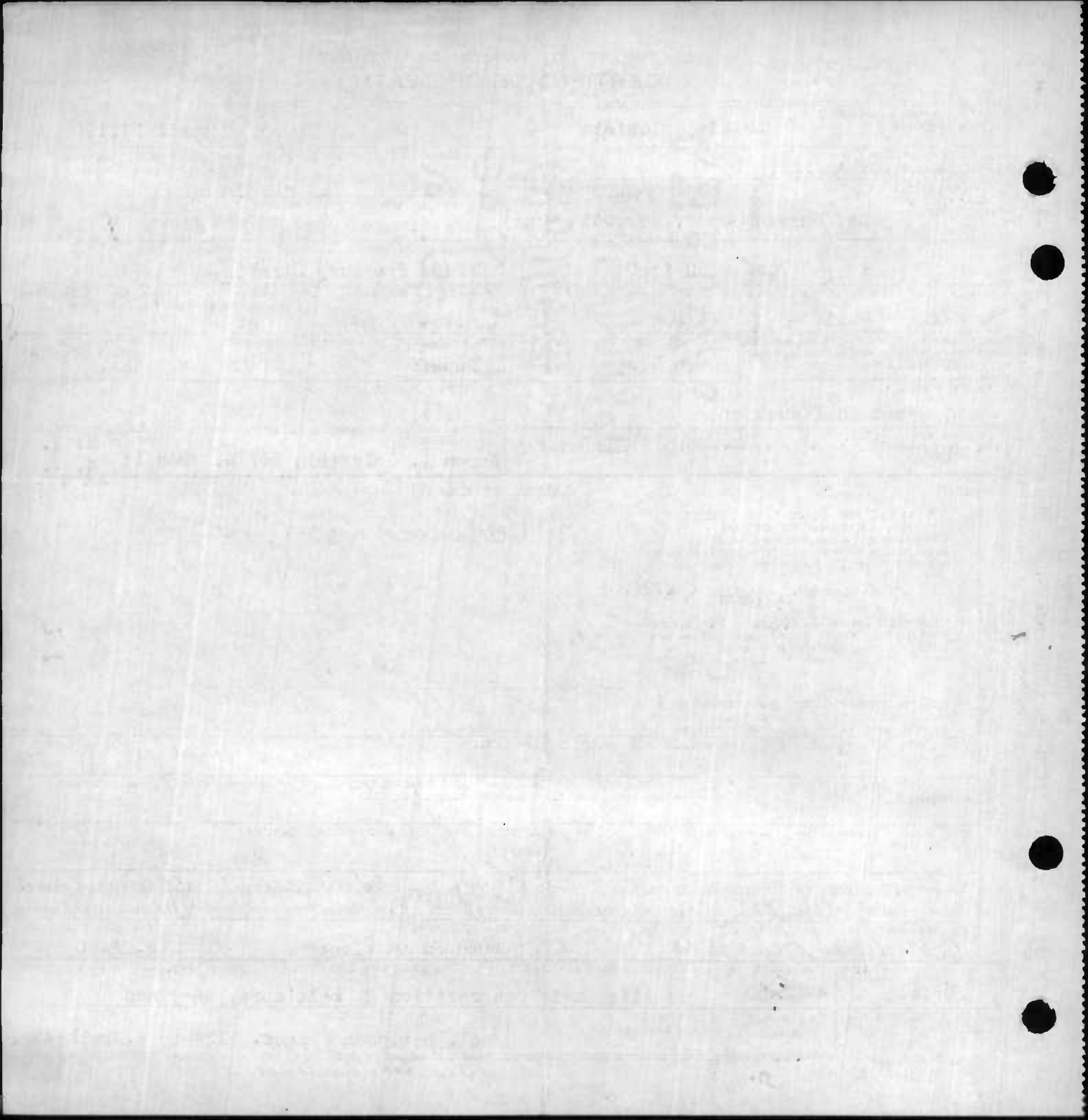
ADDRESS

Sol. Levinson &amp; Bros. 1124-26 W. North Ave.

Benton Levinson

APR 23 1950

477



W-523

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3729

BIRTH NO. 50 3729

1. NAME OF DECEASED (Type or Print) <i>Isadore Weinstein</i>			2. DATE OF DEATH <i>4/22/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Univ. Hosp.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 22-19</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>4012 W. Rogers Ave</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>7/19</i>		9. AGE (In years last birthday) <i>39</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Joecman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>mens Caps</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Max</i>			14. MOTHER'S MAIDEN NAME <i>Ella</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Rebecca Weinstein 4012 Rogers Ave</i>		

18. <i>4-20-11</i>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Acute Myocardial Infarction</i>		
	DUE TO <i>2 Ventricular Fibrillation (E.K.C.)</i>		
	(B) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Coronary Artery Disease</i>		
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Generalized Arteriosclerosis</i>			

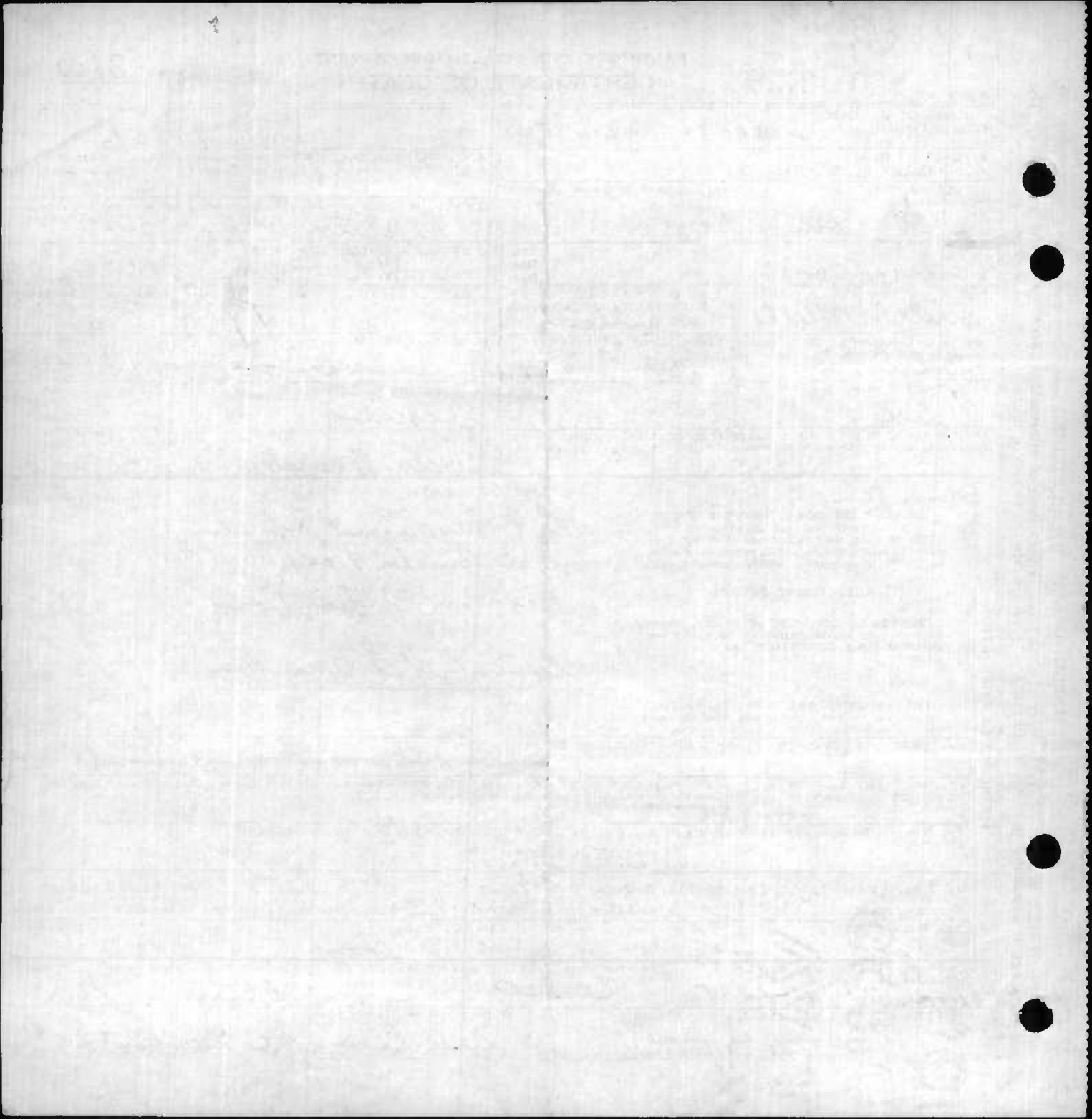
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-22</i> , 19 <i>50</i> , to <i>4-22</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>4-22</i> , 19 <i>50</i> , and that death occurred at <i>9:40</i> A.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>John G. Swisher Jr.</i>		23B. ADDRESS <i>Univ. Hosp.</i>		23C. DATE SIGNED <i>4-22-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-23-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25. FUNERAL DIRECTOR ADDRESS <i>Thurston Williams, Inc. Jack Lewis 2100 Easton Pl</i>			

APR 23 1950

31606

94a

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





M-220 CERTIFICATE CORRECTED 5-2-50  
 MS--81043 50 3730 BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH Registered No. 50 3730

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph Mazyka - MAZEIKA

2. DATE  
OF  
DEATH

4-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Baltimore City Hospitals

31 4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

21-02

D. STREET ADDRESS (If rural, give location)

1243 James St. (Baltimore City Hospitals)

c. Length of stay in Baltimore

22 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Single

8. DATE OF BIRTH

? ? ?

9. AGE (In years  
last birthday)

(86) ? 87

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Sailor

10B. KIND OF BUSINESS OR  
INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

20

13. FATHER'S NAME

Anton (D)

14. MOTHER'S MAIDEN NAME

Not know

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records\* 4940 Eastern Ave.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 4-19-1943 to 4-19-1950, that I last saw the  
deceased alive on 4-19-1950, and that death occurred at 3:50P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Ave.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 23 1951

Huntington Williams, M.D.

J. A. Grubhaugh, Jr. 1905 E. Pratt St

CERTIFICATE OF DEATH

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

W. J. FINE

R-200 50 3731

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3731

BIRTH NO. 50-08899

1. NAME OF DECEASED (Type or Print) <b>BABY GIRL ROUSSEY</b>			2. DATE OF DEATH <b>4-22-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Bon SECOURS HOSPITAL</b> <b>34</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 20-08</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			O. STREET ADDRESS (If rural, give location) <b>123 S. COLLINS AVE</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>4-22-50</b>	9. AGE (In years last birthday)	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>FRED ROUSSEY</b>			14. MOTHER'S MAIDEN NAME <b>Josephine BROCATO</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <b>750X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>I</b> <b>CAUSE OF DEATH</b> (A) <b>cerebral anoxia</b> DUE TO (B) <b>congenital anencephalia</b> DUE TO (C) <b>mother's Polyhydramnios</b>			INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>9:00 A</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>D. Schnohler</b>	23B. ADDRESS <b>Bon Secours Hosp.</b>	23C. DATE SIGNED <b>4/22/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>APRIL 24 '50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>POPLAR SPRINGS</b>	24D. LOCATION (City, town, or county) (State) <b>POPLAR SPRINGS MD</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>Harry A. Wolff, 5141 EDMONDSON AVE</b>	

APR 23 1950

157c

BABY GIRL

Benjamin Harrison

J-622

50 3732

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3732

BIRTH NO.		50 3732	
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Joseph J. Jerosch		April 21/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE	
8942 Bradford St		Maryland	
C. Length of stay in Baltimore		B. COUNTY	
66 Yrs. Mos. Days		Baltimore 7-03	
5. SEX		8. DATE OF BIRTH	
M		Feb. 16, 1884	
6. COLOR OR RACE		9. AGE (In years last birthday)	
W		66	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		11. BIRTHPLACE (State or foreign country)	
Married		Baltimore	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY?	
Copper Smelter		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Jerosch		Barbara Kuba	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		812-10-1758	
17. INFORMANT		ADDRESS	
Louise Kuebler Jerosch			
18. 331X I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Hemorrhage (Apoplexy) 3 mos	
ANTECEDENT CAUSES		(B) Generalized Arteriosclerosis ?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/20 1950 to 4/21 1950 that I last saw the deceased alive on 4/20 1950 and that death occurred at 4:30 PM from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	
Joseph Pokorny M.D.		3200 E Madison St	
23C. DATE SIGNED			
4/21/50			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		4-24-50	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Holy Redeemer			
DATE RECEIVED BY LOCAL REGISTRAR		25. FUNERAL DIRECTOR	
APR 23 1950		Thurston Williams, M.D.	
REGISTRAR'S SIGNATURE		ADDRESS	
		Frank Brocks 900 E. Chate	

VS 150

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1000 1000 1000 1000 1000

1000 1000 1000 1000 1000  
1000 1000 1000 1000 1000



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3733  
Registered No.

BIRTH NO. 50 3733

1. NAME OF DECEASED  
(Type or Print)

Lennie Phillips

2. DATE  
OF DEATH

4/22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

502 Gold St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

502 Gold St.

14-03

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 20, 1899

9. AGE (In years  
last birthday)

50

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Elevator operator

10B. KIND OF BUSINESS OR INDUSTRY

Public

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H. Gough

14. MOTHER'S MAIDEN NAME

Annie Briscoe

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

215-05-1032

17. INFORMANT

Mrs. Lottie Phillips

ADDRESS

456 A. 14th St.

18. 490 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Labor Pneumonia

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/6, 1950, to 4/22, 1950, that I last saw the deceased alive on 4/21, 1950 and that death occurred at 6 A.M., from the causes and on the date stated above.

23A. SIGNATURE

B. M. R. Helth

23B. ADDRESS

M. O. 2135 D. Hill St.

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/25/1950

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

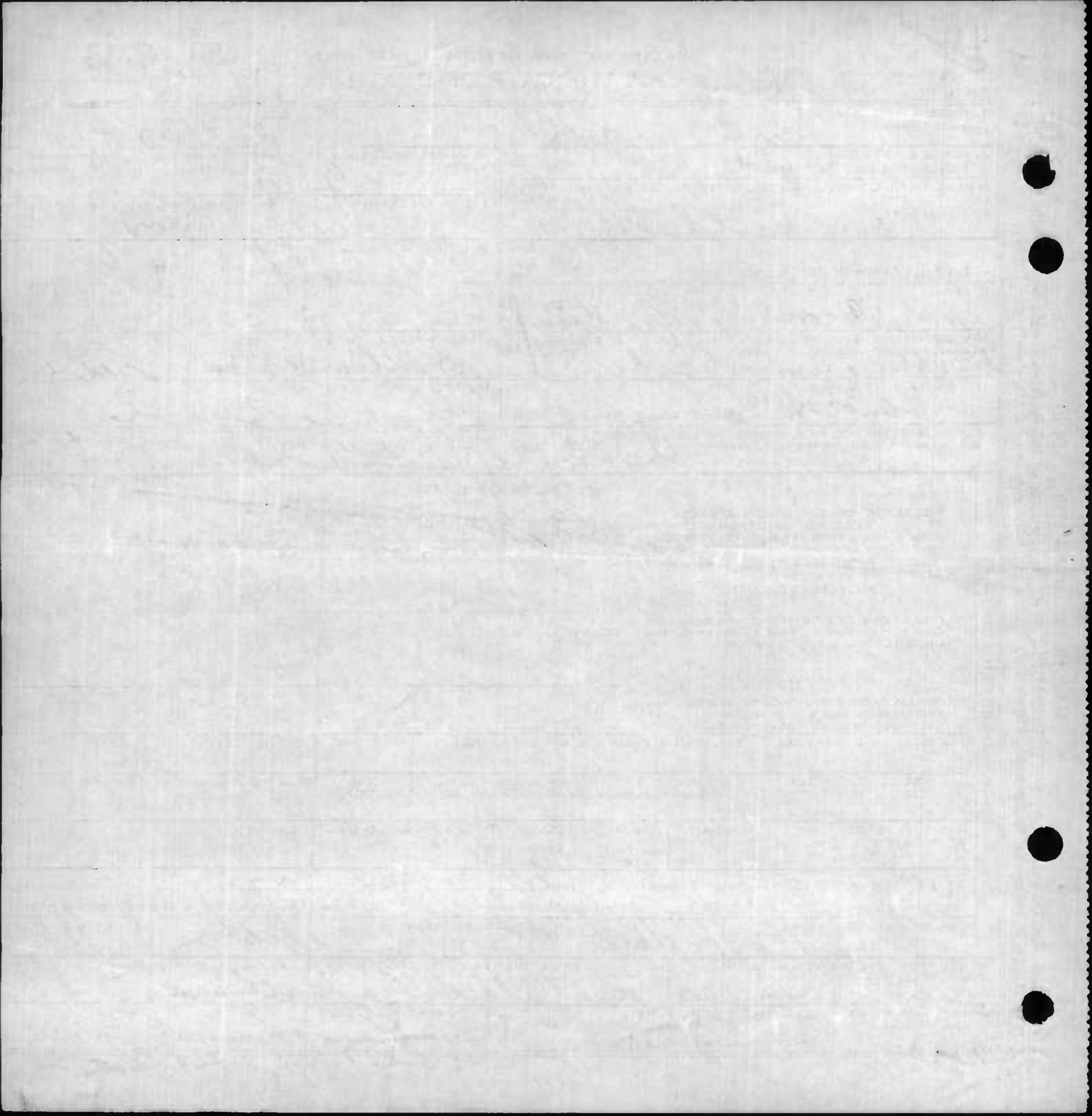
Holland Funeral Home

1631 N. Mount St. Baltimore, Md.

APR 23 1950

73081

108



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3734  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jessie

SNEAD

2. DATE OF DEATH  
April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2106 Divison St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2106 Division St.

c. Length of stay in Baltimore

36 yrs

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Nov. 15, 1907

9. AGE (In years last birthday)

42

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Building trade

11. BIRTHPLACE (State or foreign country)

Grunesland, N.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Snead

14. MOTHER'S MAIDEN NAME

Mollie Eaton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
218-07-988517. INFORMANT ADDRESS  
Mrs. Grace Kendall 2106 Division ST

18.

420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Myocardial infarction  
DUE TO Arterial Hypertension

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT ☐ WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

R. S. Fisher

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
April 22, 195024A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

4/26/1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Holland Funeral Home  
1631 Druid Hill Ave.

STANDARD STATEMENT

NAME		DATE	
ADDRESS		CITY	
STATE		COUNTY	
ZIP		FEDERAL ID	
EMPLOYER		POSITION	
SALARY		BENEFITS	
TAXES		OTHER	
REMARKS		SIGNATURE	
DATE		INITIALS	
FINGERPRINTS		PHOTOGRAPH	
TESTIMONY		INTERVIEW	
SUBJECT		OFFICIAL	
FILE NO.		PAGE NO.	

A-325

50 3735

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3735

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH ALLEN ADDISON JR.

2. DATE  
OF  
DEATH

April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

1226 N. Gilmore Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1226 N. Gilmore Street

c. Length of stay in Baltimore

35 yrs.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 5, 1882

9. AGE (In years  
last birthday)

67

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR  
INDUSTRY

Wholesale drugs

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Addison Sr.

14. MOTHER'S MAIDEN NAME

Henrietta Lanham

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sarah Addison 1226 N. Gilmore St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Severely Arteriosclerotic

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from Feb 15, 1949 to April 21, 1950, that I last saw the  
deceased alive on April 4, 1950; and that death occurred at 12:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Albert J. Shochat

23B. ADDRESS

2302 Edmonson Ave

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/23/1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Holland Funeral Home  
1631 Druid Hill Ave.

APR 23 1950

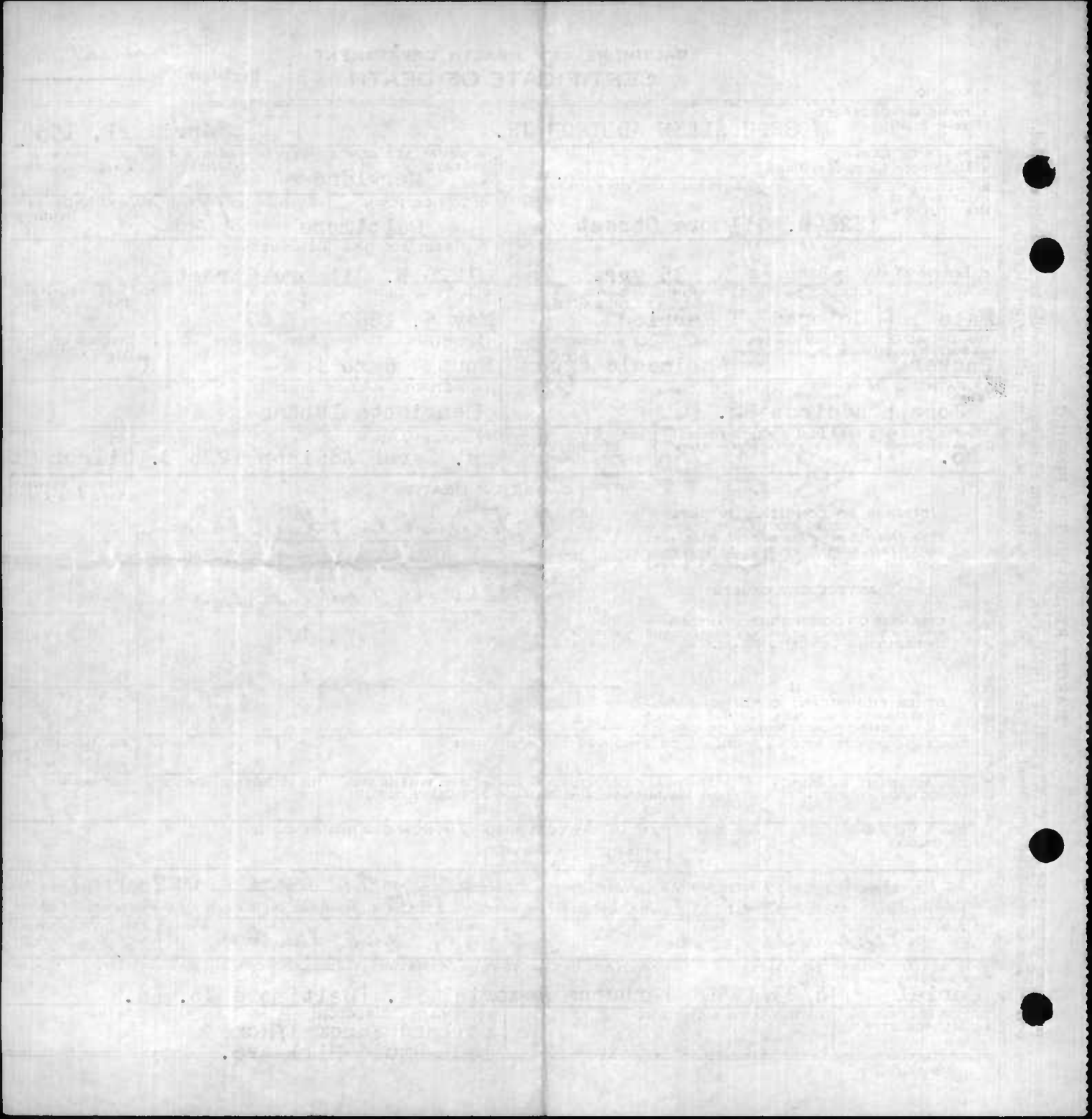
49660

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3736  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Miss Anna Smith (Anna A. Smith)

2. DATE  
OF  
DEATH

April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Harford

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1400 N. Caroline Street

St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Benson

6200

D. STREET ADDRESS (If rural, give location)

Benson, Maryland

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Fe.

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 7th. 1873

9. AGE (In years last birthday)

77

10. Under 1 Year Months: Days

0 14

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Benson

Harford Co., Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Smith

14. MOTHER'S MAIDEN NAME

Catherine Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Mr. George L. Smith-Benson, Harford Co., Md.

18. 450-1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, Rt. lower lobe

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac Failure

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Senile Arteriosclerosis

Raynaud's Left Hand

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/8/1950, to 4/21/1950 that I last saw the deceased alive on 4/21/1950, and that death occurred at 10:40 AM., from the causes and on the date stated above.

23A. SIGNATURE

Signature

23B. ADDRESS

M. D.

1400 N. Caroline Street

23C. DATE SIGNED

4/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-24-50

24C. NAME OF CEMETERY OR CREMATORY

St. Johns, Cemetery

24D. LOCATION (City, town, or county)

Long Green, Balto: Co. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Signature

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc. - 1735 Harford Avenue  
Baltimore, Md.

APR 23 1950  
VS 150

107

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH

REPORT OF

DATE

REPORT OF

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.

50 3737

50 3737

1. NAME OF DECEASED  
(Type or Print)

LOULIE KIDD

2. DATE  
OF  
DEATH

4/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

West Baltimore General Hosp.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

13-06

D. STREET ADDRESS (If rural, give location)

3501 Elm Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

NOV 24 1870

9. AGE (In years  
last birthday)

79

If Under 1 Year  
Months: DaysIf Under 24 hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHN F. McMULLEN - 3501 ELM AVE.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cardiovascular accident  
(possibly portine hemorrhage)

3 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertensive arteriosclerosis c. v. disease

unknown

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/24/50, 19\_\_, to 4/24/50, 19\_\_, that I last saw the  
deceased alive on 4/24/50, 19\_\_, and that death occurred at 11 AM m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Sheen

M. D.

23B. ADDRESS

West 1st

23C. DATE SIGNED

4/24

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

APRIL 24/50

MT. OLIVET

FREDERICK RD.

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Austin E. Donovan - 3818 Roland Ave

APR 23 1950

93D



W-536 50 3738

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3738

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES W. WINTER

2. DATE  
OF  
DEATH

9/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Mary Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balt. 9-03

D. STREET ADDRESS (If rural, give location)

706 E. 33RD ST.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED.

8. DATE OF BIRTH

Nov 17, 1862

9. AGE (In years  
last birthday)

87

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tailor, Shirt

10b. KIND OF BUSINESS OR INDUSTRY

Clothing

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CHARLES W. WINTER

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Acute Pulm. Edema

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Auricular Fibrillation  
Myocardial Degeneration

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Coronary Sclerosis

General arterio Sclerosis.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/21/1950, to 9/22/1950, that I last saw the deceased alive on 9/22/1950, and that death occurred at 5:20 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Roberts

23B. ADDRESS

Mary

23C. DATE SIGNED

9/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county) (State)

Woodlawn

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

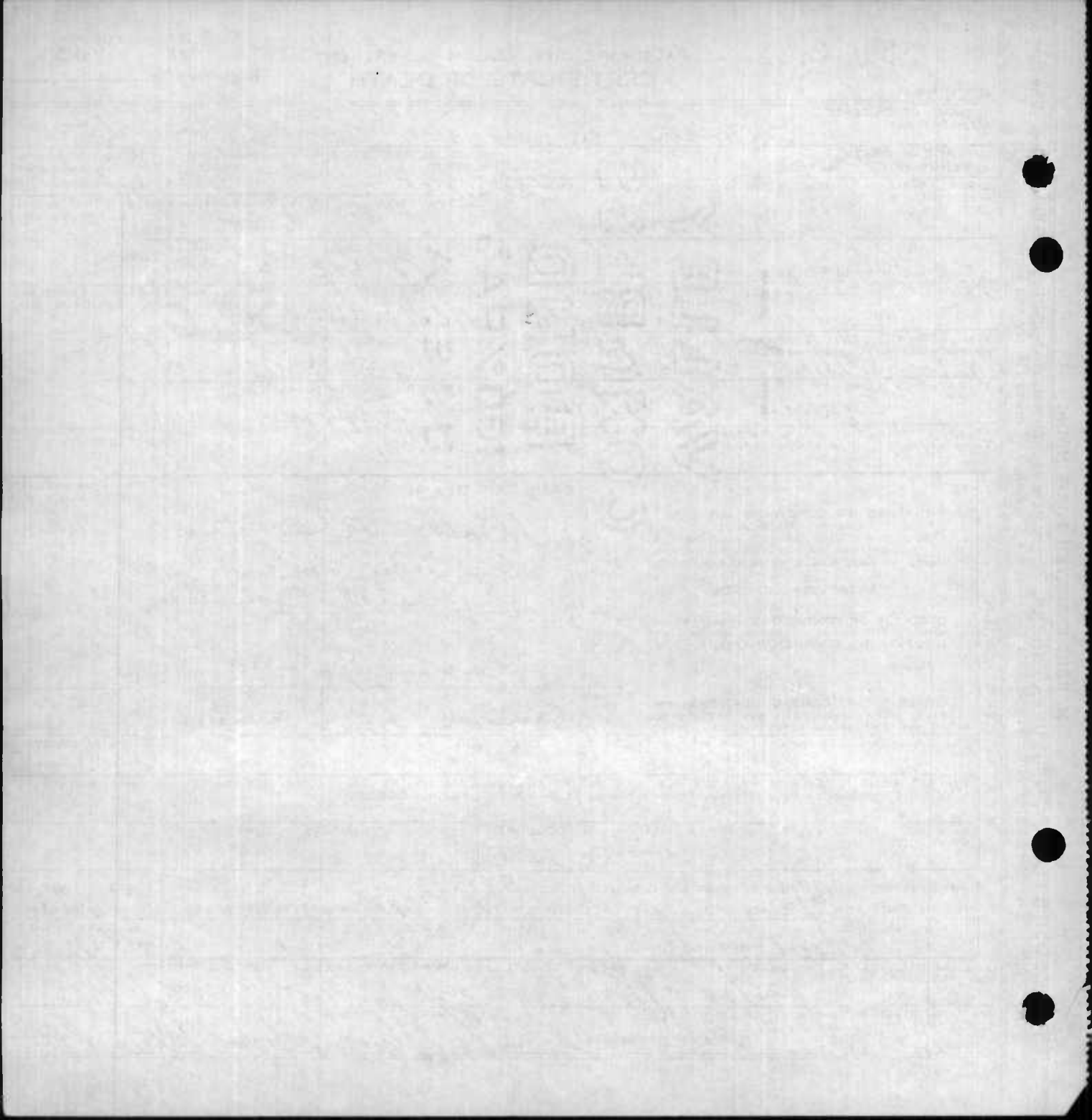
25. FUNERAL DIRECTOR

William Roberts

ADDRESS

147 St Paul







5-165 50 3739

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3739  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Albert Severn 283286

2. DATE  
OF  
DEATH

APR 22 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Harford

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Aberdeen

6200

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

MAXA ROAD R.F.D. 1

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year If Under 24 Hours  
Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INCOME HOSPITAL

ADDRESS

18. 592 X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Chronic nephritis  
DUE TO  
with uremia

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from 4-17-50 to 4-22-1950, that I last saw the deceased alive on 4-22-1950, and that death occurred at JOHNS HOPKINS HOSPITAL from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Huntington Williams, M.D.

1254 St Paul St

Know all men by these presents, that ALFRED E. BROWN

of the County of Dallas, State of Texas, for and in consideration of the sum of Five Hundred and no/100 Dollars, to him in hand paid by MAXA LINDA M.D.

the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said MAXA LINDA M.D.

all that certain Tract of Land

situated in the County of Dallas, State of Texas, to-wit:

Tract of Land

containing Five Acres, more or less, the corners of which are

marked by Iron Nails

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

and the same is more fully described in the plat of survey

hereunto attached and made a part hereof, and the same is

more fully described in the plat of survey hereunto attached

and made a part hereof, and the same is more fully described

in the plat of survey hereunto attached and made a part hereof,

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3740  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MRS. BERTHA SINCLAIR

2. DATE  
OF  
DEATH

4/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Maryland General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-14

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

4425 Wickford Rd #10

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

2/6/00

9. AGE (In years  
last birthday)

50

10. Under 1 Year  
Months: Days

2 17

11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Adolph Herman Freedom

14. MOTHER'S MAIDEN NAME

Jennie Freeman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Adolph Freedom 1031 St. Paul St.

18.

153 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

Carcinomatosis

Carcinoma of transverse  
colon

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

April 12, 1950  
Jan 23, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of transverse colon

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., home  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/18, 1950, to 4/23, 1950, that I last saw the  
deceased alive on 4/23, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles J. Black Jr.

23B. ADDRESS

Maryland General

23C. DATE SIGNED

4/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn

24D. LOCATION (City, town, or county)

Woodlawn Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook Inc. 1217 St. Paul St.

APR 24 1950  
VS 150

46E

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		MARRIED		OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
CERTIFICATE OF DEATH		STATE OF NEW YORK		COUNTY OF		CITY OF		TOWN OF		VILLAGE OF	
DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		MARRIED		OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF DECEASED	
CERTIFICATE OF DEATH		STATE OF NEW YORK		COUNTY OF		CITY OF		TOWN OF		VILLAGE OF	

Y-526

50 3741

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Baila Yaniger</b>			2. DATE OF DEATH <b>April 23, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>4613 ParkHeights Ave</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>35 yrs</b> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>3507 Callaway Ave</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>1870</b>	9. AGE (in years, last birthday) <b>80</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>
13. FATHER'S NAME <b>Barish Fishbone</b>			14. MOTHER'S MAIDEN NAME <b>Vella Rudmah</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Mrs Bessie Fishman 3507 Callaway Ave</b>		

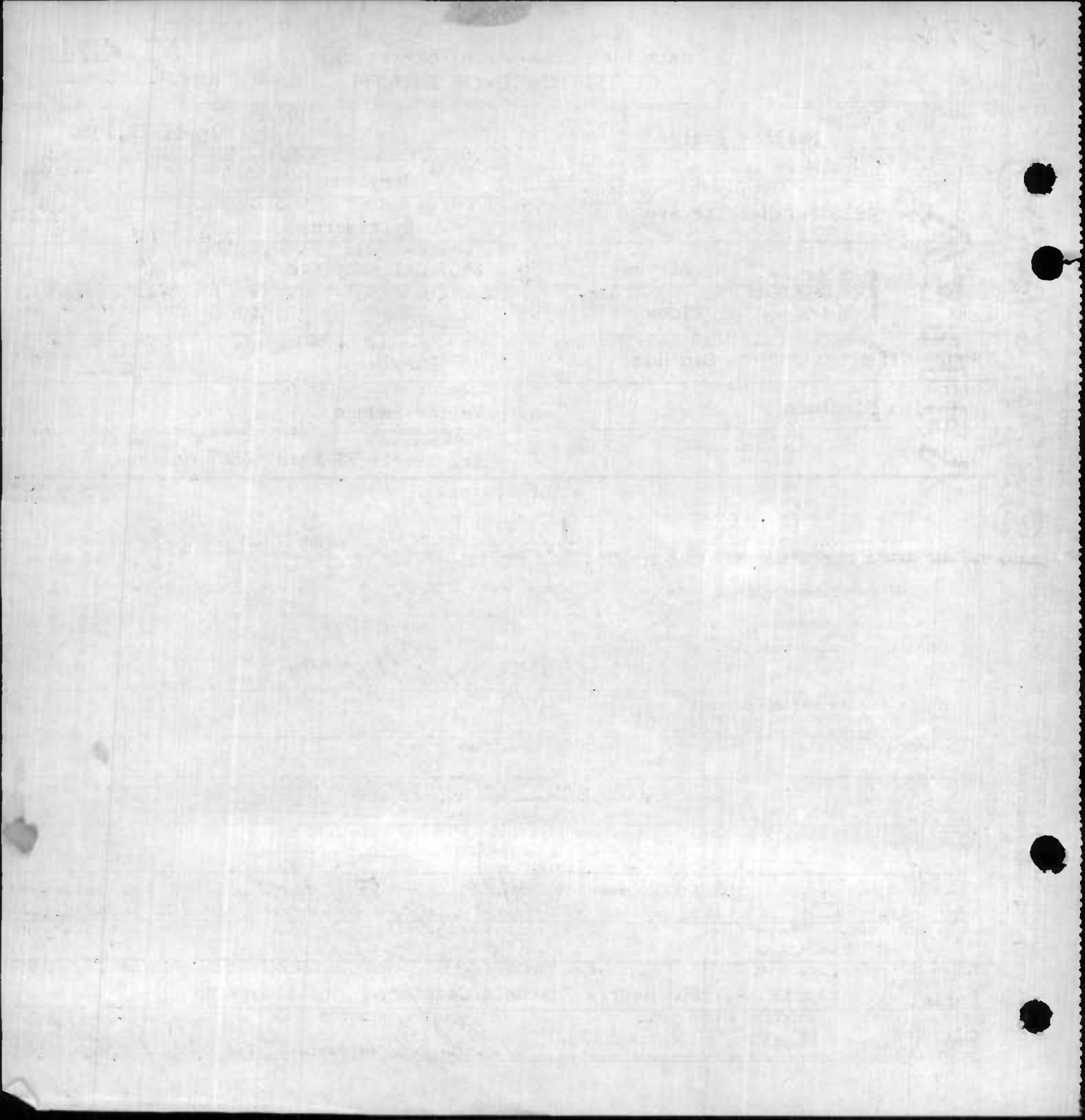
18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Cerebral Hemorrhage</b> (A) DUE TO <b>Cerebral Sclerosis</b> ANTECEDENT CAUSES (B) DUE TO <b>Chronic Sclerosis</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/11</b> , 19 <b>50</b> , to <b>4/23</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/23</b> , 19 <b>50</b> , and that death occurred at <b>9:15</b> a. m., from the causes and on the date stated above.			
23A. SIGNATURE <b>R. Hornstein</b>	M. D.	23B. ADDRESS <b>204 E. Biddle St</b>	23C. DATE SIGNED <b>4/23/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 24, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Rosedale Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 24 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>Sol Rabinowitz Bros W North ave</b> <b>83a</b>	

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3742

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas Redgrave

2. DATE  
OF  
DEATH

April 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

Wilkins

D. STREET ADDRESS (If rural, give location)

Found along railroad tracks at Gwynn Falls near Ave. Park

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Unknown

8. DATE OF BIRTH

Unknown

9. AGE (In years last birthday)

45

10. Under 1 Year 11. Under 24 Hours

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

Unknown

ADDRESS

18. 3220

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute alcoholism

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Exposure

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

April 14, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL APR 21 1950

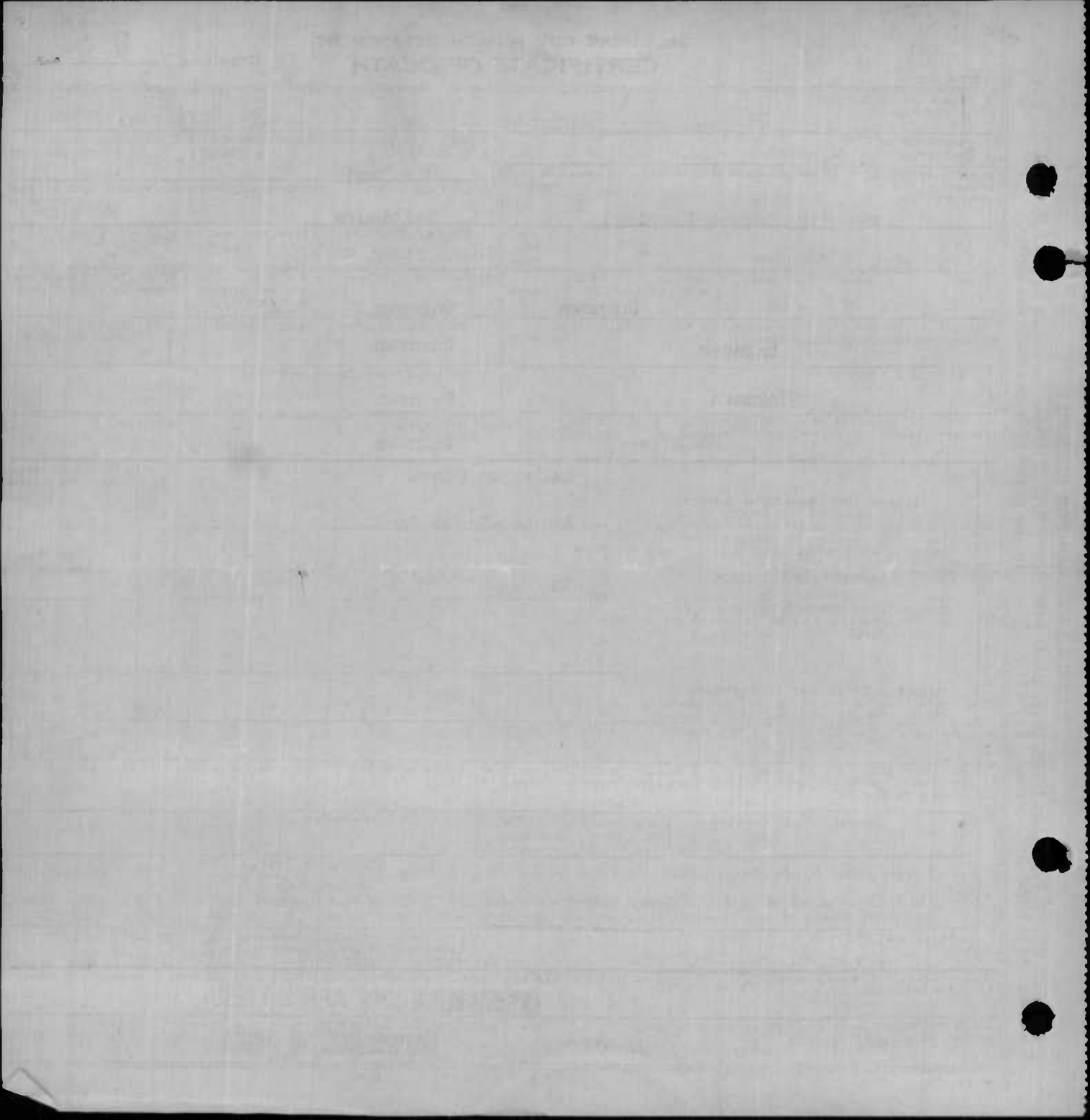
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3743**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Ida Brown*2. DATE  
OF  
DEATH**April 8, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)**Maryland**

C. CITY OR TOWN

**Baltimore**

(If outside corporate limits, write RURAL and give township)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION**Provident Hospital**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

**1024 Wilmer Court**

5. SEX

**F**

6. COLOR OR RACE

**C**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**Unknown**

8. DATE OF BIRTH

9. AGE (In years  
last birthday)**83**If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**Unknown**10B. KIND OF BUSINESS OR  
INDUSTRY**Unknown**

11. BIRTHPLACE (State or foreign country)

**Unknown**12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

**Unknown**

14. MOTHER'S MAIDEN NAME

**Unknown**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)**Unknown**16. SOCIAL  
SECURITY NO.

17. INFORMANT

**Unknown**

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT**2nd & 3rd Burns**INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☒  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)**Home**21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

**1024 Wilmer Court**21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY**Unknown**

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Found burned in home - probably accident**22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: **natural causes** ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Emil H. Boyer*

23B. CHIEF MEDICAL EXAMINER

M.D.

23C. DATE SIGNED

**19 April 1950**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**UNIVERSITY MEDICAL SCHOOL APR 21 1950**DATE RECEIVED BY  
LOCAL REGISTRAR

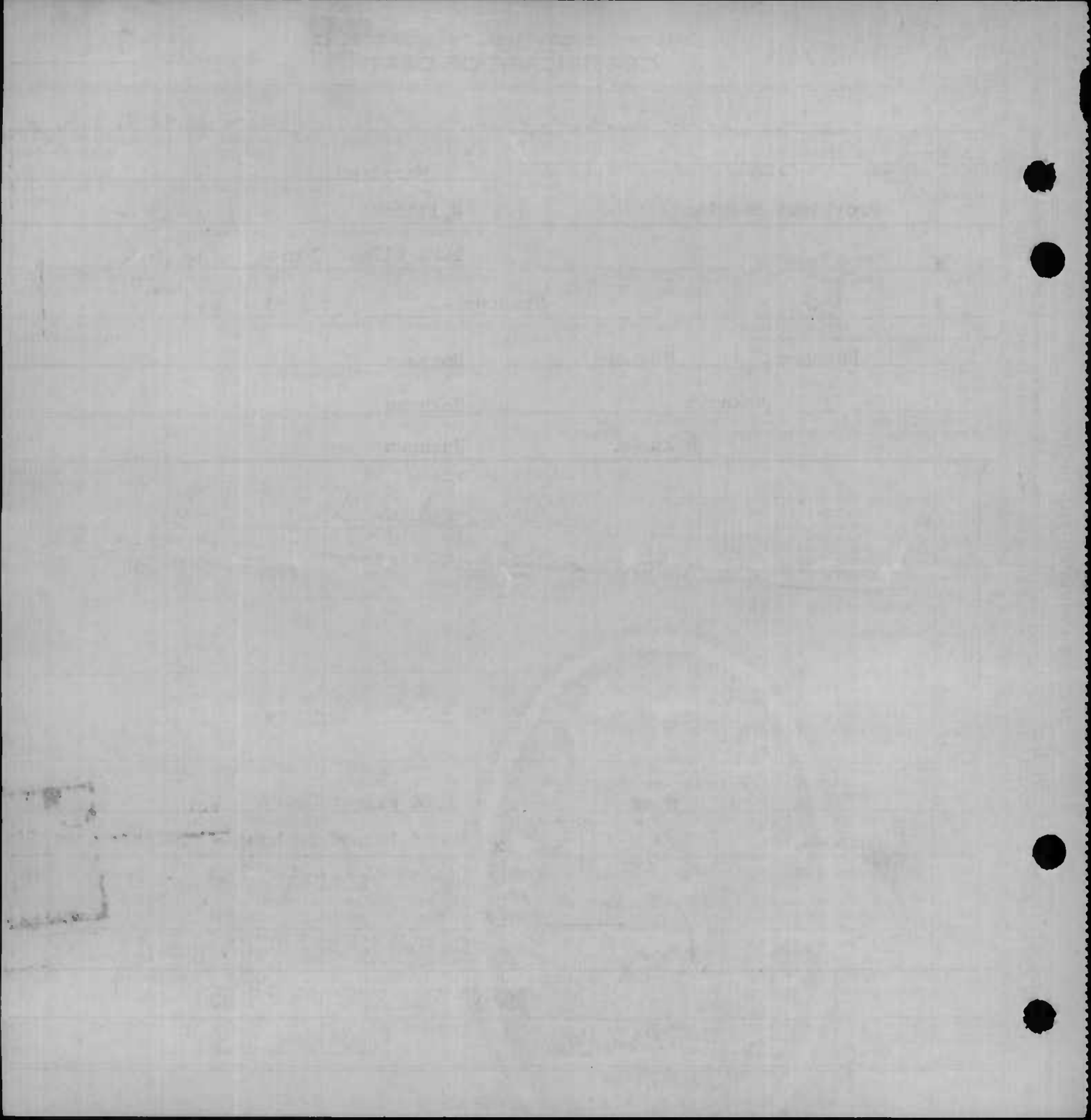
REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

**Commissioner of Health**

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Howard

WETMORE

2. DATE  
OF  
DEATH

April 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

2305 St. Paul St., Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

2305 St. Paul St., Nursing Home

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

W

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Unknown

8. DATE OF BIRTH

Unknown

9. AGE (In years  
last birthday)

83

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

Unknown

16. SOCIAL  
SECURITY NO.

Unknown

17. INFORMANT

Unknown

ADDRESS

18.

443 X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

12 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardio-  
Vascular Disease

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 11, 1950, to April 12, 1950, that I last saw the  
deceased alive on April 12, 1950, and that death occurred at 2:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert B. Tunney

M. D.

23B. ADDRESS

920 St Paul St

23C. DATE SIGNED

4-12-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL APR 21 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

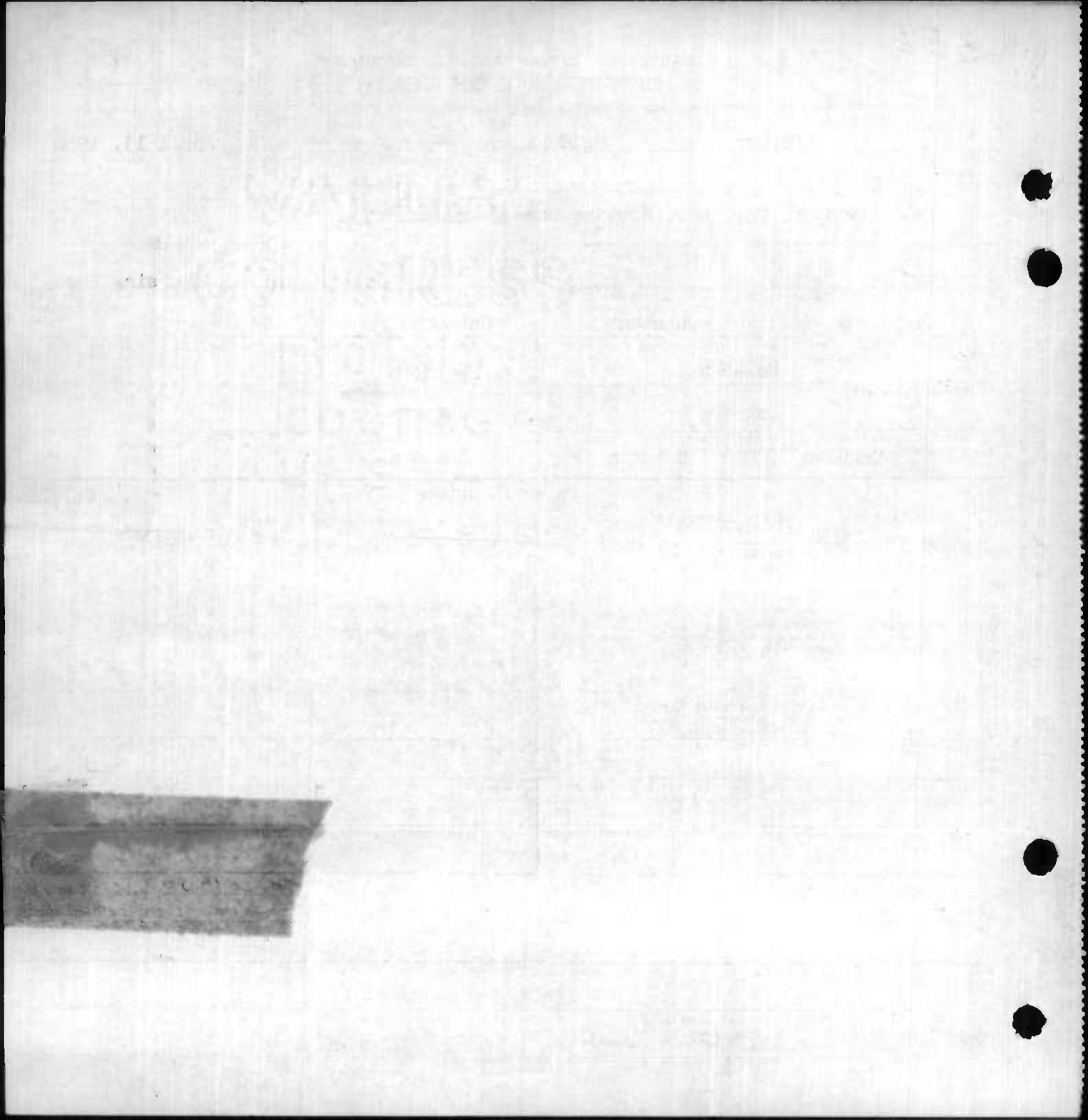
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3745  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Clara Howard*

2. DATE  
OF  
DEATH

APR 20 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Hale & Rury*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION *JOHN HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*349 Camp St*

*12-07*

c. Length of stay in Baltimore

*45 Yrs.*

5. SEX

*Female*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*9-28-1887*

9. AGE (In years last birthday)

*62*

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*MD*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*ISAAC W. LIMER*

14. MOTHER'S MAIDEN NAME

*IDA. MAE ?*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

*JOHN HOPKINS HOSPITAL*

ADDRESS

18. *155X*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

*Intestinal Obstruction (Small bowel)*

DUE TO

(B)

*metastatic carcinoma of gall bladder*

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Arteriosclerotic Heart Disease*

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

*4-18-50*

19B. MAJOR FINDINGS OF OPERATION

*metastatic Adenocarcinoma*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-18-50* to *4-20-50*, that I last saw the deceased alive on *4-20-50*, and that death occurred at *10:25 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Walter Lawrence Jr.*

23B. ADDRESS

*JOHN HOPKINS HOSPITAL*

23C. DATE SIGNED

*4-21-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*BURIAL*

24B. DATE

*4-24-50*

24C. NAME OF CEMETERY OR CREMATORY

*MT. CALVARY*

24D. LOCATION (City, town, or county)

*A.A. COUNTY, Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

*Joseph H. Locks, Jr. 1351 N. Central Ave*

ADDRESS

APR 24 1950

VS 150

46F

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE  
JANUARY 18, 1904  
REPORT OF THE  
COMMISSIONERS OF THE  
LAND OFFICE

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS.

1904

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3746

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

IDA M. SHAWKER

2. DATE  
OF  
DEATH

4/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

347 S. WOODYEAR ST

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 19-03

D. STREET ADDRESS (If rural, give location)

347 S. WOODYEAR ST

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

5. SEX

FEMALE

White

MARRIED

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

OCT 2, 1889

9. AGE (In years last birthday)

60

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

THOMAS MORAN

14. MOTHER'S MAIDEN NAME

ELLA SHEILDs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

CHARLES E. SHAWKER

ADDRESS

347 S. WOODYEAR

18. 260X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Branchopneumonia

DUE TO

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vascular-Renal Disease 10 yrs

DUE TO

(C) Diabetes, severe

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Blindness, total

2 1/2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1944, to April, 1950, that I last saw the deceased alive on 2 April, 1950, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

H. Bayless

23B. ADDRESS

1600 Wilkins Dr

23C. DATE SIGNED

22 April 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Olivet

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 24 1950

REGISTRAR'S SIGNATURE

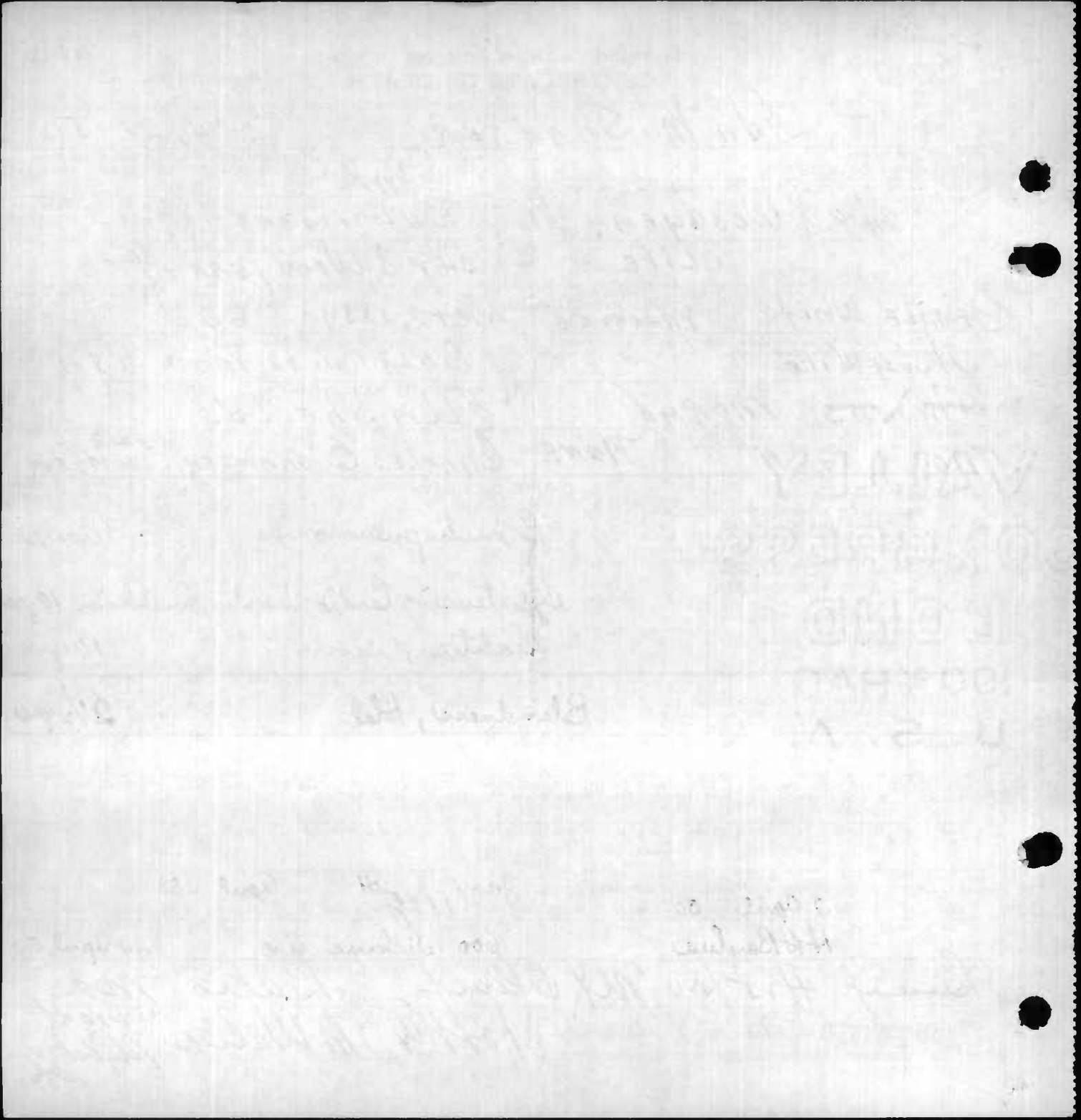
Huntington Williams, MD

25. FUNERAL DIRECTOR

R. M. Walters

ADDRESS

Pratt Strick



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 3747**

 BIRTH NO. **50 3747**

1. NAME OF DECEASED (Type or Print) <b>MORRIS WEISTOCK</b>			2. DATE OF DEATH <b>4-23-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>4613 Park Heights</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mt Sinai Home</b>			C. CITY OR TOWN (If outside corporate limits, write R.R.A. and give township) <b>Baltimore 27-18</b>		
C. Length of stay in Baltimore <b>40</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>5430 Nelson Ave</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH		9. AGE (In years, last birthday) <b>79</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paper business</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Samuel</b>			14. MOTHER'S MAIDEN NAME <b>not known</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Sam Weistak 3909-58th S.E. Wash D.C.</b>	

18. <b>470.1</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) ANTECEDENT CAUSES		DUE TO <b>Acute Myocardial Failure</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO <b>Ch. coronary disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO <b>Acute Bronchopneumonia</b>			

19A. DATE OF OPERATION <b>4/23/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/18/50</b> , to <b>4/23/50</b> , that I last saw the deceased alive on <b>4/23/50</b> , and that death occurred at <b>21</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Rich. Hornstein</b>		23B. ADDRESS <b>204 E. Biddle St</b>		23C. DATE SIGNED <b>4/24/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Heaven Mt. Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Beth., Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Jace Heine Inc., 2400-02 Eutaw Place</b>			



Hoerstem  
204 E Middle St



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3748

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Abraham Tarses

2. DATE  
OF  
DEATH

4/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

MARYLAND GENERAL HOSPT.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE 27-16

c. Length of stay in Baltimore

44

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2461 OLD SPRING LANE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

May 2, 1888

9. AGE (In years  
last birthday)

61

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR  
INDUSTRY

SELF

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

AARON

14. MOTHER'S MAIDEN NAME

PESSIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ROSE TARSES - 2461 OLD SPRING LANE

18.

420.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

23A. SIGNATURE

William J. Helrich

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

4-24-1950

24C. NAME OF CEMETERY OR CREMATORY

NORTH POINT ROAD

24D. LOCATION (City, town, or county) (State)

BALTIMORE

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 24 1950

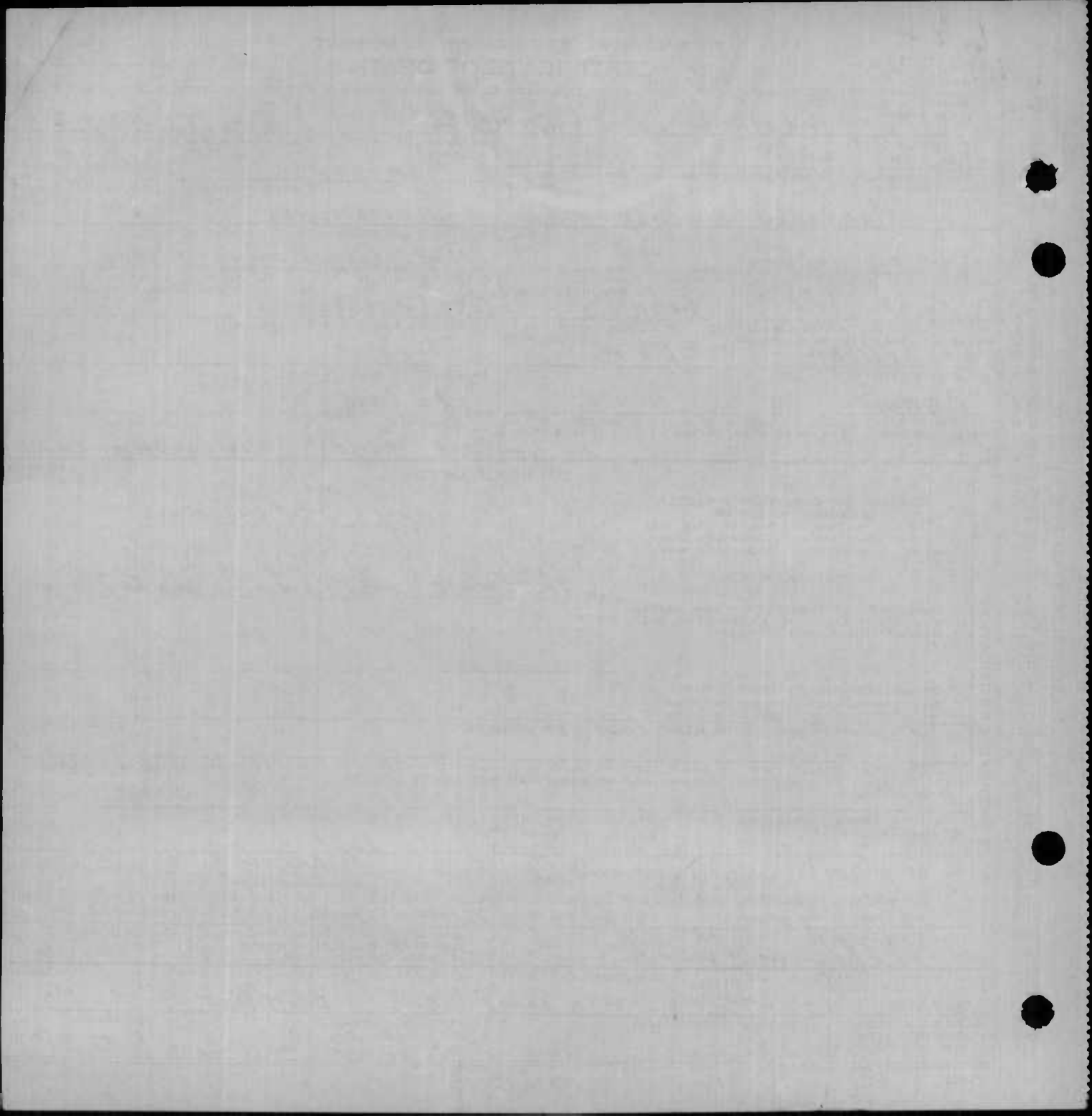
REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis Inc. 200 Eutan Pl

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EARL ANDERSON

2. DATE  
OF  
DEATH

4/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

MD.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

1307 FREMONT AVE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTO

c. Length of stay in Baltimore

30

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1307 FREMONT AVE

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1/07/09

9. AGE (In years  
last birthday) 11 Under 1 Year  
Months: Days: Hours: Min.

41

2

26

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

PORTER

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

ATLANTIC CITY NJ

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

EARL ANDERSON

14. MOTHER'S MAIDEN NAME

VASHTI ANDERSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

VASHTI ANDERSON

1307 FREMONT

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) CARDIO VASCULAR  
DISEASE

2 YRS?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) BROKEN COMPENSATION

1 MO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK22. I hereby certify that I attended the deceased from Sept 09, 1950 to April 22, 1950, that I last saw the  
deceased alive on Apr 22, 1950, and that death occurred at 12 m., from the causes and on the date stated above.

23A. SIGNATURE

William Frey

M. D.

23B. ADDRESS

1928 Penna Ave

23C. DATE SIGNED

4/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

April 25/50 Mt Auburn Balto

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Huntington Williams, M.D.

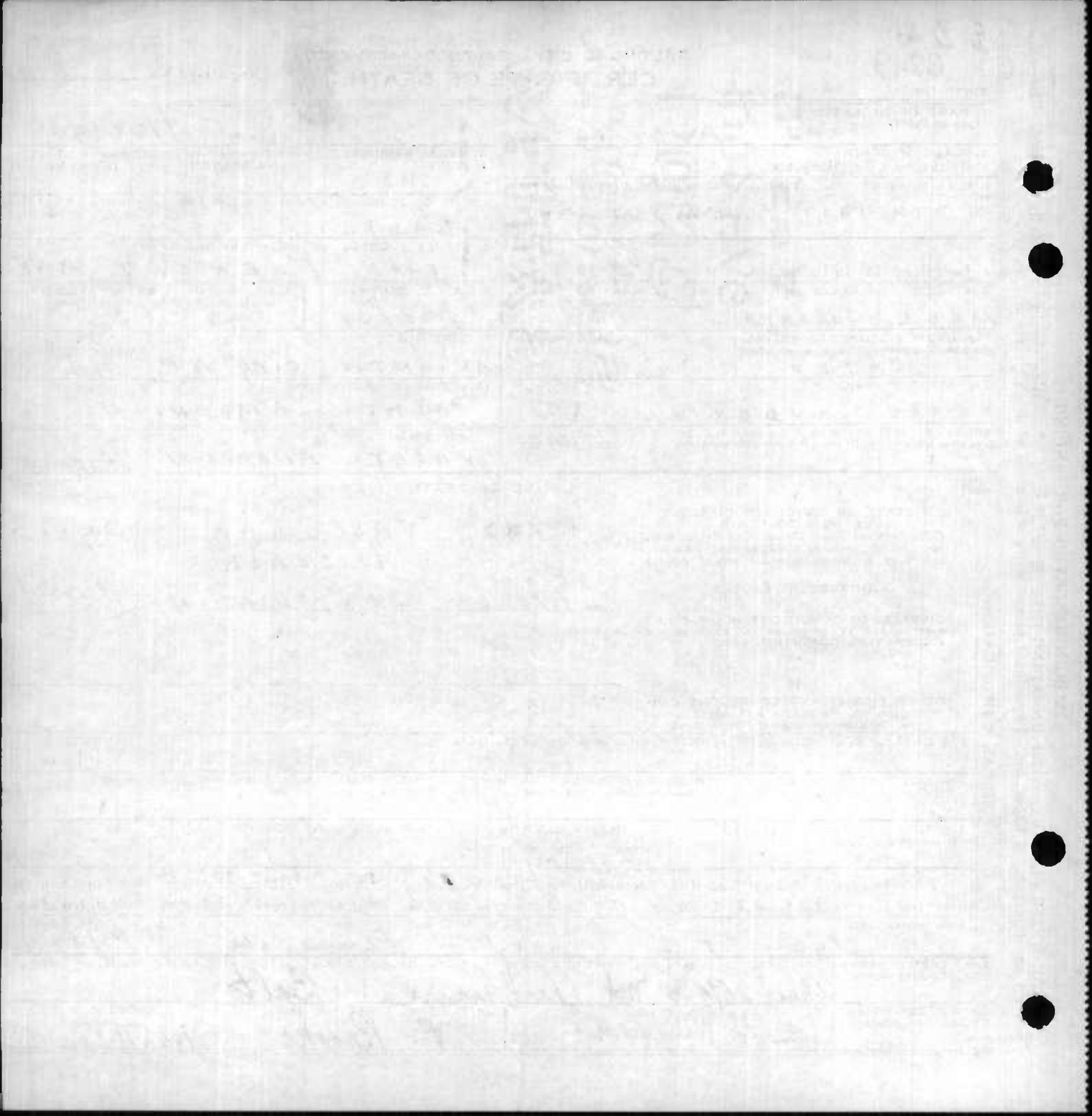
V. Brooks

14637 Cany St

VS 150

75080

937



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3750

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Patricia Erway

2. DATE OF DEATH

Apr 23, 1950

3. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)  
A. STATE

Pa

B. COUNTY

V-35

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Wellsboro

D. STREET ADDRESS (If rural, give location)

100 East WE

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

7544

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Cardiac Failure following operation for congenital cyanotic heart disease  
(B)  
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3/26, 1950, to 4/23, 1950, that I last saw the deceased alive on 4/23, 1950, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Thurston Williams, M.D.

Thurston Williams, M.D.

1. The purpose of this report is to provide information on the activities of the various groups and individuals who are active in the field of defense.

2. The information was obtained from a confidential source who has provided reliable information in the past.

3. The information was obtained from a confidential source who has provided reliable information in the past.



46B

STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERIFICATE OF DEATH

NAME OF DECEASED \_\_\_\_\_

AGE \_\_\_\_\_

SEX \_\_\_\_\_

DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_

Cause of Death \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Signature of Registrar \_\_\_\_\_

Signature of Coroner \_\_\_\_\_

Signature of Medical Examiner \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

Signature of \_\_\_\_\_

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3752

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

G. Judd

STEVENS

2. DATE  
OF  
DEATH

April 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2120 N. Fulton Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

January 14, 1867

9. AGE (In years  
last birthday)

83

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Real Estate Operator

10B. KIND OF BUSINESS OR  
INDUSTRY

Real Estate

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. John Hasenmayer

ADDRESS

46 S. Wyoming Ave.  
Ardmore, Pa.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held on Insp. & Inq. thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

RS Frober

M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

April 20, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Frederick Rd. Balto. Md

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 24 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tickner &amp; Sons - Nolla Ave

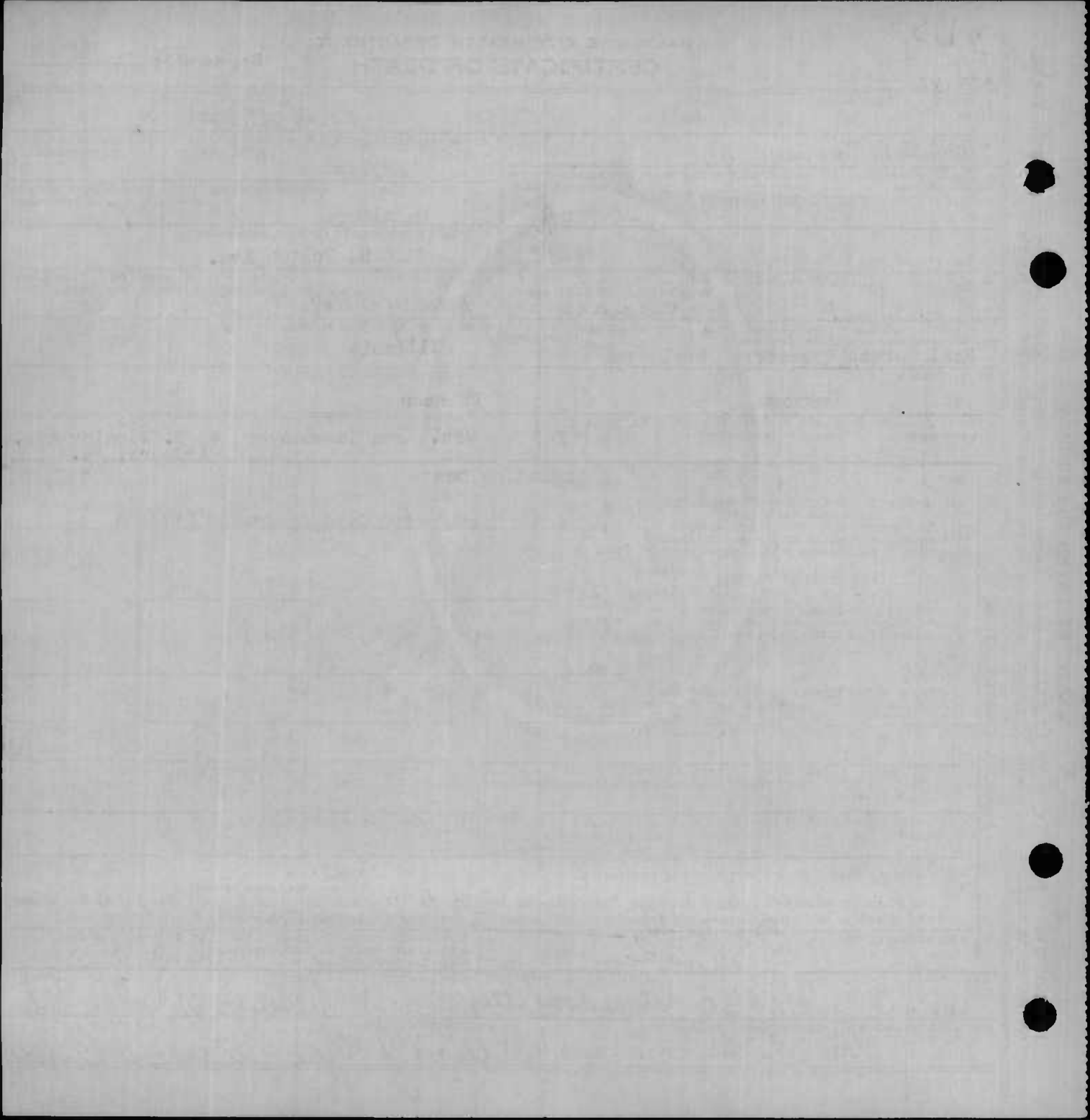
ADDRESS

Nolla Ave

VS 151

937 ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 3753

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

H. VERNON LEITCH

2. DATE  
OF  
DEATH

4-23-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OF TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

709 W. University Parkway

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 29, 1891

9. AGE (In years, last birthday) Months: Days

58

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Trust Officer

10B. KIND OF BUSINESS OR INDUSTRY

Bank

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY?

American

13. FATHER'S NAME

John Vincent Leitch

14. MOTHER'S MAIDEN NAME

Ella B. Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

World War #1

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Pkwy

Mrs. Elsie S. Leitch

709 W. University

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Myocardial Thrombosis  
DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

11 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)   
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)   
DUE TO

19A. DATE OF OPERATION

4-16-50

19B. MAJOR FINDINGS OF OPERATION

Myocardial Thrombosis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-15, 1950, to 4-23, 1950, that I last saw the deceased alive on 4-23, 1950, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Sam R. Brown

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

4-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Wm. J. Lickner & Sons

ADDRESS

APR 24 1950

VS 150

1568V

99

UNITED STATES GOVERNMENT  
CENTRAL INTELLIGENCE AGENCY

CONFIDENTIAL

1. NAME (Last, first, middle initial)	2. DATE OF BIRTH (MM/DD/YYYY)
3. PLACE OF BIRTH (City, State, Country)	4. CURRENT ADDRESS (Street, City, State, ZIP)
5. OCCUPATION (Job title, Employer)	6. EDUCATION (Degree, Institution)
7. MARITAL STATUS (Single, Married, Divorced, Widowed)	8. RELIGION (If any)
9. POLITICAL AFFILIATION (Party, Organization)	10. SOCIAL SECURITY NUMBER (If any)
11. EMPLOYMENT HISTORY (Employer, Dates)	12. TRAVEL HISTORY (Countries, Dates)
13. EDUCATION HISTORY (Institution, Dates)	14. MILITARY SERVICE (Branch, Dates)
15. CRIMINAL RECORD (Offenses, Dates)	16. FINANCIAL RECORD (Assets, Liabilities)
17. PSYCHOLOGICAL EVALUATION (Assessment, Date)	18. PHYSICAL EXAMINATION (Findings, Date)
19. MEDICAL HISTORY (Conditions, Treatments)	20. DRUG USE (Substances, Dates)
21. ALCOHOL CONSUMPTION (Frequency, Quantity)	22. TObacco Use (Frequency, Quantity)
23. SEXUAL ACTIVITY (Partners, Dates)	24. REPRODUCTION (Children, Dates)
25. OTHER INFORMATION (Notes, Comments)	26. SIGNATURE (Name, Date)



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3754

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ROSA NAZARENUS

2. DATE  
OF  
DEATH

April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2735 Presbury St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

2735 Presbury St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

May 18, 1879

9. AGE (In years last birthday)

70

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Schwartzenberg

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Evelyn Brackbill

3810 Ferndale Ave

18. 334X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

apoplexy

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

one week  
5

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Apr 14, 1950, to Apr 21, 1950, that I last saw the deceased alive on Apr 21, 1950, and that death occurred at 12:30 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/24/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

DATE RECEIVED BY: REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR

Huntington Williams, Jr.

Thm. J. Dickner + Sons Valetto Md.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3755

Registered No. \_\_\_\_\_

BIRTH NO. 50 3755

1. NAME OF DECEASED (Type or Print) <u>Richard Fitzgerald</u>			2. DATE OF DEATH <u>April 22, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>10-02</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Home</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
C. Length of stay in Baltimore <u>30 yrs</u>			D. STREET ADDRESS (If rural, give location) <u>1304 E. Monument St</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/10/1890</u>		9. AGE (In years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Truck Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>✓</u>
13. FATHER'S NAME <u>Thomas Fitzgerald</u>			14. MOTHER'S MAIDEN NAME <u>Louise</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Elmer Fitzgerald</u>		ADDRESS <u>1304 Monument St</u>

MEDICAL CERTIFICATION	18. <u>443 X</u> CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Bronchopneumonia</u>		<u>3 DAYS</u>
	DUE TO		
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Cerebral Hemorrhage</u>		<u>5 DAYS</u>
	DUE TO		
	<u>Hypertensive Cardio-Vascular Disease</u>		<u>2 YEARS</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>JANUARY 1, 1950</u> , to <u>April 22, 1950</u> , that I last saw the deceased alive on <u>April 20, 1950</u> , and that death occurred at <u>2:55 A.M.</u> , from the causes and on the date stated above.				
23A. SIGNATURE <u>Medwin N. Borden</u>	M. D.	23B. ADDRESS <u>2030 W. Fayette St</u>	23C. DATE SIGNED <u>4/22/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/27/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Prospect Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Cross Va.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 24 1950</u>		REGISTRAR'S SIGNATURE <u>William H. Williams</u>		
		25. FUNERAL DIRECTOR OR ADDRESS <u>Charles H. Porter</u>		

DEPARTMENT OF HEALTH SERVICES  
STATE OF CALIFORNIA  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Medical Examiner		13. Signature of Coroner		14. Signature of County Clerk		15. Signature of State Registrar	
16. Signature of Hospital Administrator		17. Signature of Funeral Home		18. Signature of Burial Place		19. Signature of Crematorium		20. Signature of Other	
21. Signature of Other		22. Signature of Other		23. Signature of Other		24. Signature of Other		25. Signature of Other	
26. Signature of Other		27. Signature of Other		28. Signature of Other		29. Signature of Other		30. Signature of Other	
31. Signature of Other		32. Signature of Other		33. Signature of Other		34. Signature of Other		35. Signature of Other	
36. Signature of Other		37. Signature of Other		38. Signature of Other		39. Signature of Other		40. Signature of Other	
41. Signature of Other		42. Signature of Other		43. Signature of Other		44. Signature of Other		45. Signature of Other	
46. Signature of Other		47. Signature of Other		48. Signature of Other		49. Signature of Other		50. Signature of Other	
51. Signature of Other		52. Signature of Other		53. Signature of Other		54. Signature of Other		55. Signature of Other	
56. Signature of Other		57. Signature of Other		58. Signature of Other		59. Signature of Other		60. Signature of Other	
61. Signature of Other		62. Signature of Other		63. Signature of Other		64. Signature of Other		65. Signature of Other	
66. Signature of Other		67. Signature of Other		68. Signature of Other		69. Signature of Other		70. Signature of Other	
71. Signature of Other		72. Signature of Other		73. Signature of Other		74. Signature of Other		75. Signature of Other	
76. Signature of Other		77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other		85. Signature of Other	
86. Signature of Other		87. Signature of Other		88. Signature of Other		89. Signature of Other		90. Signature of Other	
91. Signature of Other		92. Signature of Other		93. Signature of Other		94. Signature of Other		95. Signature of Other	
96. Signature of Other		97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3756

BIRTH NO. 50 3756

1. NAME OF DECEASED  
(Type or Print)

Sylvester Patrick

2. DATE  
OF  
DEATH

4-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street address or location)

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

231 S. Green St.

c. Length of stay in Baltimore

56 yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Sep.

8. DATE OF BIRTH

Dec. 31, 1875

9. AGE (in years

last birthday)

74

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sailor

10B. KIND OF BUSINESS OR

INDUSTRY

Strauss Bros.

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Simon

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.Generalized Arteriosclerosis, Tabes  
Dorsalis

19A. DATE OF OPERATION

7-24-48

19B. MAJOR FINDINGS OF OPERATION

Gastro Intestinal Hemorrhage

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-15-39, 19 to April 21, 1950 that I last saw the deceased alive on April 21, 1950 and that death occurred at 1.30 PM, from the causes and on the date stated above.

23A. SIGNATURE

J. S. O'Brien M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-21-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

4430 Belair Rd.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

John J. Cowan &amp; Son

11011

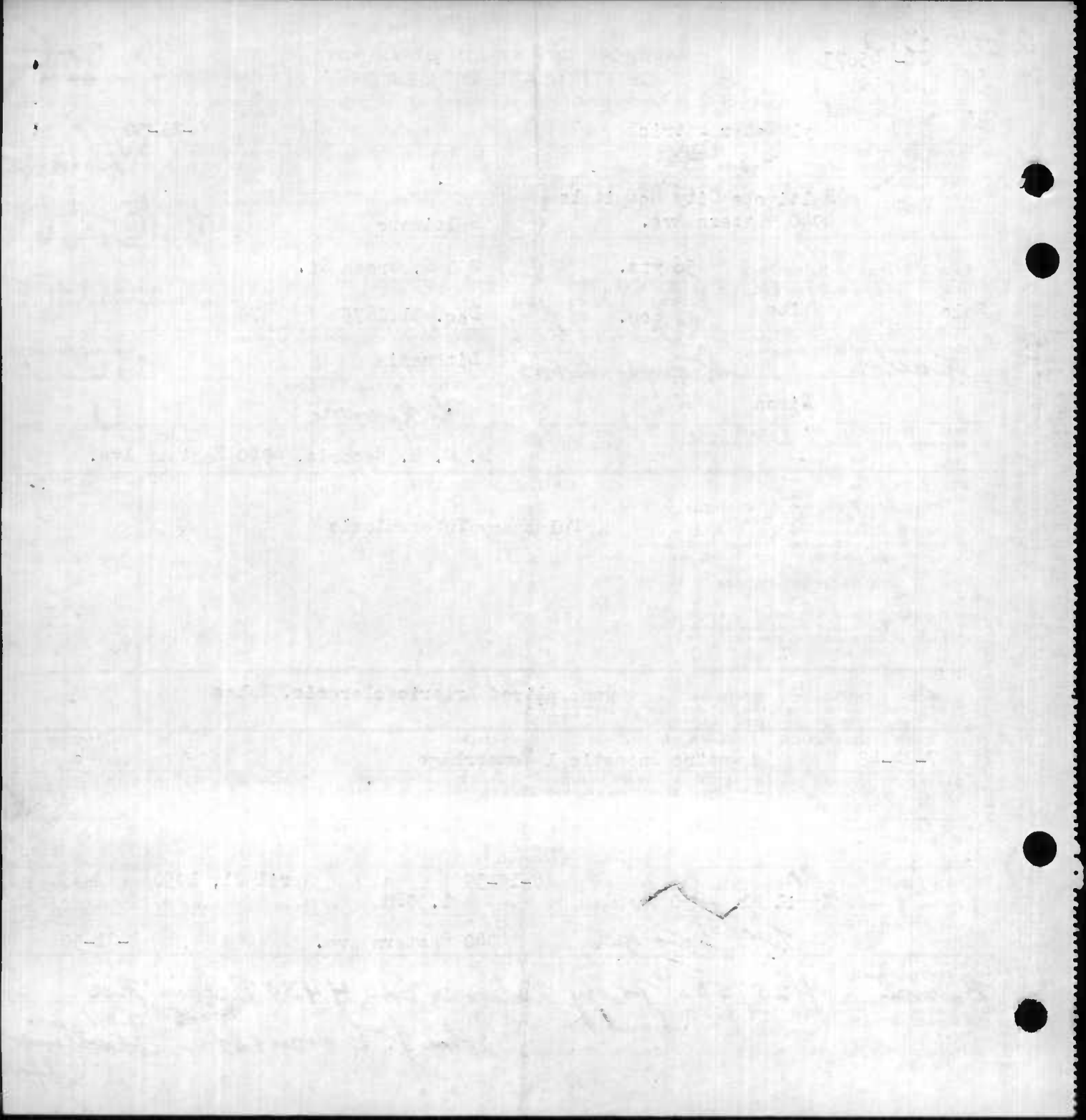
APR 24 1950

VS 150

36006

13B St.







MARGIN RESERVED FOR BINDING

M-236  
50 3757

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3757  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>James P. M<sup>c</sup> Dermott</i>		2. DATE OF DEATH <i>4/22/50</i>	
3. PLACE OF DEATH a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>2-0</i>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>231 So. Regester St.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>Life</i>		d. STREET ADDRESS (If rural, give location) <i>231 So. Regester St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>1/25/1910</i>
9. AGE (In years, last birthday) <i>40</i>		10. Under 1 Year Months: <i>3</i> Days: <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of life; if ever retired) <i>maintainance man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Columbia Specialty Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Patrick M<sup>c</sup> Dermott</i>		14. MOTHER'S MAIDEN NAME <i>Bridget Parson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Margaret E. M<sup>c</sup> Dermott</i>		ADDRESS <i>231 So. Regester St.</i>	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>acute</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Angina Pectoris</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>April 22, 1950</i> , to <i>April 22, 1950</i> , that I last saw the deceased alive on <i>April 22, 1950</i> , and that death occurred at <i>10:54 a.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Mark Temple</i>	23B. ADDRESS <i>2002 E. Pratt St.</i>	23C. DATE SIGNED <i>4/22/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4/26/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>
24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd. Baltimore, Md.</i>		25. FUNERAL DIRECTOR <i>John J. Cowan &amp; Son</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 24 1950</i>	REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i>	ADDRESS <i>942 St.</i>

33630

942 St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WALTON  
STATION  
MASS.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3758

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Martha Estelle Brown

2. DATE  
OF  
DEATH

4/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence  
before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

9-06

D. STREET ADDRESS (If rural, give location)

2719 Hugo Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

March 10, 1887

9. AGE (In years  
last birthday)

63 yrs.

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Greenberry A. Pearce

14. MOTHER'S MAIDEN NAME

Martha Simms

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Frank Brown (Husband) - Same

18. 540.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)Generalized arteriosclerosis acute  
myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Congestive heart failure  
due to  
sartian ulcer

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3-29-50

19B. MAJOR FINDINGS OF OPERATION

Mass in lower ventral sac.

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from March 22, 1950, to April 23, 1950, that I last saw the  
deceased alive on April 23, 1950, and that death occurred at 5:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Huntington Williams, M.D.

L.J. Luck

5305 Hayford Rd

Perforation posterior gastric ulcer. Letter in document file  
cancer not present.

50-3758 6/20/50.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3759  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES B. LANG

2. DATE  
OF DEATH April 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan 8 1915

9. AGE (In years  
last birthday)

35

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Pat Backriver Rt

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Lang

14. MOTHER'S MAIDEN NAME

Mary Hortschneider

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-10-4327

17. INFORMANT

ADDRESS

Lydia A. Lang 3717 Centre Place

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Artery Disease

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Carl L. Royer

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 25, 1950 Holy Redeemer Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

4430 Belair Road Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 24 1950

REGISTRAR'S SIGNATURE

Franklin Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Sippel Bros 1800 E Lombard St

## CERTIFICATE OF DEATH

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912

JAN 1 1912



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3780

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thelma Marshall

2. DATE  
OF  
DEATH

April 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8-07

c. Length of stay in Baltimore

Signe

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug.

9. AGE (In years  
last birthday)

48

10. Under 1 Year  
Months Days

11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House Work

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Swiss Coleman

14. MOTHER'S MAIDEN NAME

Rachel Denny

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Bertha Marshall 2004 E Biddle

ADDRESS

18.

442X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Hypertensive Cardio-Vascular  
Renal Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, J.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

April 24, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Buried

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Westbury Cemetery

24D. LOCATION (City, town, or county)

AA Co Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 24 1950

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

Wm. H. Kammer, J.

ADDRESS

1515 Maryland St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully spelled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL  
NO DISSEMINATION  
NO REPRODUCTION

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3761

50 3761  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM LITTLETON FULLER</b>			2. DATE OF DEATH <b>4/23/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS, Hospt.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>TOWSON 5200</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>313 E Joppa Rd.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-25-1900</b>	9. AGE (In years last birthday) <b>49</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor of Training</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Esso Standard Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>WILLIAM H. FULLER</b>		
14. MOTHER'S MAIDEN NAME <b>JULIA SIFORD</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W.I</b>		
16. SOCIAL SECURITY NO. <b>214-01-5681</b>			17. INFORMANT ADDRESS <b>MRS. GRACE FULLER - TOWSON, MD.</b>		
18. <b>420.1</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <b>MYOCARDIAL INFARCTION</b> DUE TO ANTECEDENT CAUSES (B) <b>CORONARY THROMBOSIS</b> DUE TO (C) <b>Bleeding gastric ulcer?</b>					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10-26</b> , 19 <b>49</b> , to <b>4-23</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-23</b> , 19 <b>50</b> , and that death occurred at <b>12:12</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>George D. Solomon Jr.</b>		23B. ADDRESS <b>Bon Secours Hospt.</b>		23C. DATE SIGNED <b>4-23-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>April 25, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>TOWSON, Md.</b>		25. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>		ADDRESS	

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE, JANUARY 15, 1914.

REPORT OF THE ATTORNEY GENERAL, JAMES C. CLARK, FOR THE YEAR 1913.

ALBANY: JAMES B. LEECH, STATE PRINTER, 1914.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3762  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH SWEENEY

2. DATE  
OF  
DEATH

4/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. Length of stay in Baltimore

6 days

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

ANNE ARUNDEL

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Glen Burnie Ferndale

D. STREET ADDRESS (If rural, give location)

HAMMONDS FERRY ROAD

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

MD. STATE ROAD COMM.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

CLIFFORD SWEENEY

14. MOTHER'S MAIDEN NAME

ALICE MAYHUE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MRS. JOSEPH SWEENEY, FERNDAL, MD.

18. 241 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Chronic cor pulmonale

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Chronic bronchial asthma

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

DUE TO

and Pulmonary emphysema

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from 4/16/1950, to 4/22/1950, that I last saw the deceased alive on 4/22/1950, and that death occurred at 1 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Haig D. Yazujian M.D.

1213

Light St.

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

GLEN HAVEN

GLEN BURNIE, MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Huntington Williams, MD

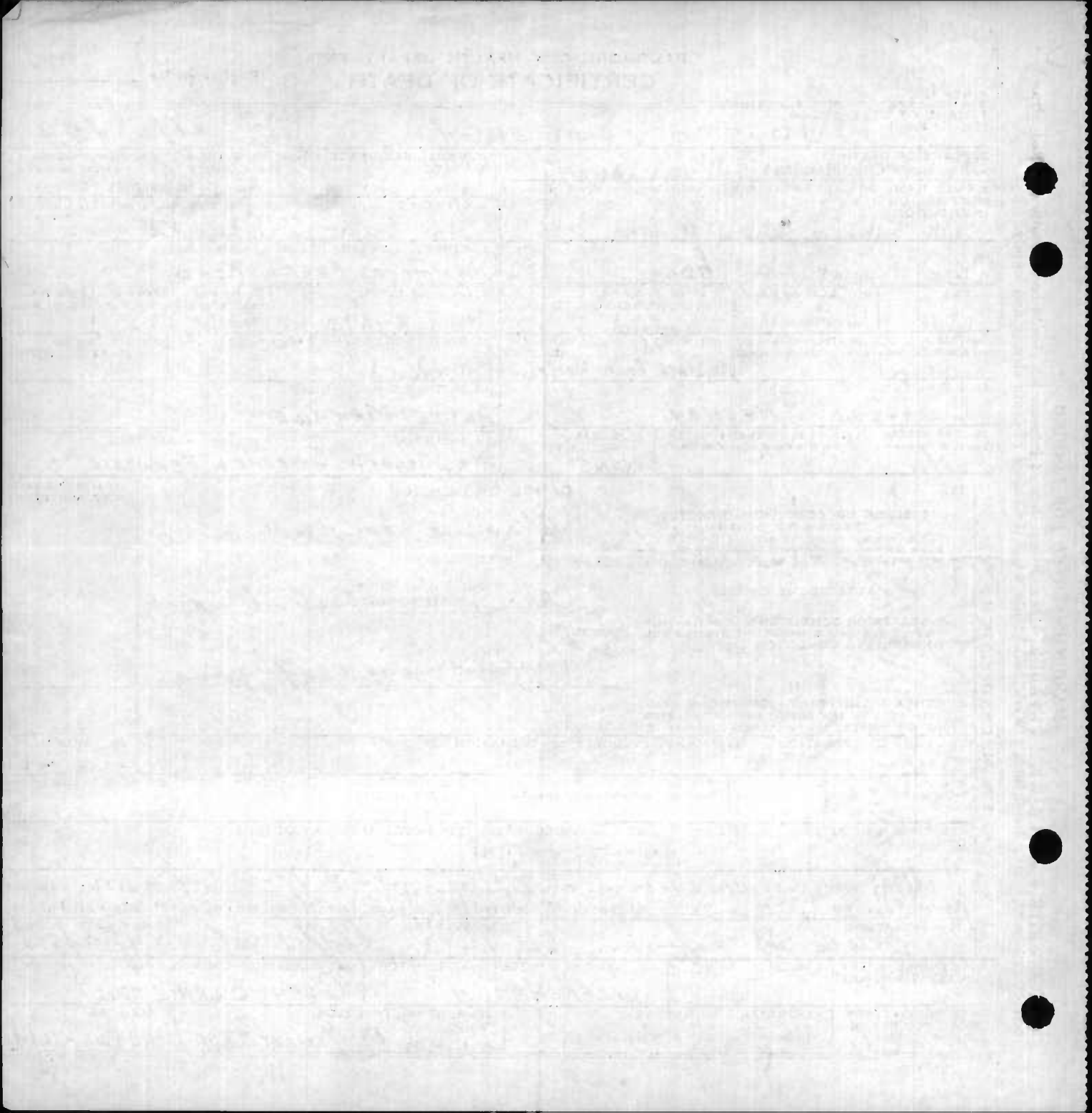
Thomas W. Slaughter Glen Burnie, MD

VS 150

Haig D. Yazujian

. 98898

112





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3763  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NANCY CHEW

2. DATE  
OF  
DEATH

4-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

MD

B. COUNTY

AA

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or  
location)

UNIVERSITY HOSPITAL

C. CITY OR TOWN

JESSUPS

(If outside corporate limits, write RURAL and give  
township)

5200

D. STREET ADDRESS (If rural, give location)

-

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

1890

9. AGE (In years  
last birthday)

60

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

SYLVESTER QUEEN

14. MOTHER'S MAIDEN NAME

EMMA HERBERT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

-

(If yes, give war or dates of service)

-

16. SOCIAL  
SECURITY NO.

-

17. INFORMANT

SAME

ADDRESS

18. 584 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

PERIPHERAL VASCULAR

COLLAPSE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

ANESTHETIC DEATH

ARTERIOSCLEROTIC HYPERTENSIVE

(C)

ACUTE CHOLECYSTITIS + CHOLELITHIASIS

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4-22-50

19B. MAJOR FINDINGS OF OPERATION

ACUTE CHOLECYSTITIS + CHOLELITHIASIS WITH HYDROPS

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

ANESTHETIC DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

UNIVERSITY HOSPITAL

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

HOSPITAL

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY4-22-50 10<sup>00</sup> P.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Injection of sodium pentothal

UNDER ANESTHESIA

22. I hereby certify that I attended the deceased from 4-22-1950, to 4-22-1950, that I last saw the  
deceased alive on 4-22-1950, and that death occurred at 10<sup>00</sup> P.m., from the causes and on the date stated above.

23A. SIGNATURE

J. J. H. H. H. H.

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

4-22-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

REGISTERAR'S SIGNATURE

Wm. H. Williams, M.D.

24C. NAME OF CEMETERY OR CREMATORY

St. Lawrence

24D. LOCATION (City, town, or county)

Jessups, A. C.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 24 1950

25. FUNERAL DIRECTOR

Mrs. H. H. H. H.

ADDRESS

1881  
1935  
5861

1935

F652

MM. 131341

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3764

BIRTH NO. 50 3764

1. NAME OF DECEASED (Type or Print) Marie, Luedtke Frankowski			2. DATE OF DEATH April 22-1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland Baltimore			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland. b. COUNTY		
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Balto. City Hospitals. 4940 Eastern Ave.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore. 19-03		
c. Length of stay in Baltimore Life Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) 1312 McHenry St.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH April, 3 -1916		9. AGE (In years last birthday) 34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Otto, Luedtke.			14. MOTHER'S MAIDEN NAME Mae. Ford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Balto. City Hospitals Records 4940 Eastern AVE.		

18. I 007 CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis.		
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-25 19 49 to April, 22, 19 50, that I last saw the deceased alive on April, 22, 19 50 and that death occurred at 6:45 AM, from the causes and on the date stated above.					
23a. SIGNATURE C. S. Hogan M. D.		23b. ADDRESS 4940 Eastern Ave.		23c. DATE SIGNED April, 22-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE April 25/50		24c. NAME OF CEMETERY OR CREMATORY Family Plot	
24d. LOCATION (City, town, or county) Glenburnie Md.		24e. LOCATION (City, town, or county) (State)			
DATE RECEIVED BY LOCAL REGISTRAR APR 24 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR KRAUSE FUNERAL HOME	
VS 150		1216 S. Charles St.		1313	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



T-230

50 3765

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3765

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary E. Toogood

2. DATE  
OF  
DEATH

April 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

756 W. Redwood St.

4. USUAL RESIDENCE (Where deceased lived, If institution, residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

756 W. Redwood St.

c. Length of stay in Baltimore

20

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 14, 1887

9. AGE (In years  
last birthday)

63

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Bavaria, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Branford

14. MOTHER'S MAIDEN NAME

Ellen Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Eda Banks 756 W. Redwood St.

ADDRESS

18.

331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH2 days  
11/1/50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension  
neglected

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 8, 1950 to Apr 21, 1950, that I last saw the  
deceased alive on Apr 21, 1950, and that death occurred at 6 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Dan Brander

M. D.

23B. ADDRESS

122 W. See

23C. DATE SIGNED

4/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 24 1950

REGISTRAR'S SIGNATURE

Thurington Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Katie P. Williams

ADDRESS

322 N. Schroeder

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully copied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of board of health		18. Signature of city council	
19. Signature of state board of health		20. Signature of federal board of health		21. Signature of national board of health	
22. Signature of international board of health		23. Signature of world board of health		24. Signature of universal board of health	
25. Signature of global board of health		26. Signature of planetary board of health		27. Signature of cosmic board of health	
28. Signature of celestial board of health		29. Signature of terrestrial board of health		30. Signature of subterranean board of health	
31. Signature of aquatic board of health		32. Signature of aerial board of health		33. Signature of ethereal board of health	
34. Signature of spiritual board of health		35. Signature of mental board of health		36. Signature of emotional board of health	
37. Signature of intellectual board of health		38. Signature of volitional board of health		39. Signature of motivational board of health	
40. Signature of behavioral board of health		41. Signature of attitudinal board of health		42. Signature of characterological board of health	
43. Signature of personality board of health		44. Signature of psychological board of health		45. Signature of physiological board of health	
46. Signature of pathological board of health		47. Signature of clinical board of health		48. Signature of diagnostic board of health	
49. Signature of therapeutic board of health		50. Signature of prognostic board of health		51. Signature of curative board of health	
52. Signature of palliative board of health		53. Signature of supportive board of health		54. Signature of rehabilitative board of health	
55. Signature of preventive board of health		56. Signature of promotive board of health		57. Signature of protective board of health	
58. Signature of restorative board of health		59. Signature of regenerative board of health		60. Signature of reconstructive board of health	
61. Signature of reparative board of health		62. Signature of reparative board of health		63. Signature of reparative board of health	
64. Signature of reparative board of health		65. Signature of reparative board of health		66. Signature of reparative board of health	
67. Signature of reparative board of health		68. Signature of reparative board of health		69. Signature of reparative board of health	
70. Signature of reparative board of health		71. Signature of reparative board of health		72. Signature of reparative board of health	
73. Signature of reparative board of health		74. Signature of reparative board of health		75. Signature of reparative board of health	
76. Signature of reparative board of health		77. Signature of reparative board of health		78. Signature of reparative board of health	
79. Signature of reparative board of health		80. Signature of reparative board of health		81. Signature of reparative board of health	
82. Signature of reparative board of health		83. Signature of reparative board of health		84. Signature of reparative board of health	
85. Signature of reparative board of health		86. Signature of reparative board of health		87. Signature of reparative board of health	
88. Signature of reparative board of health		89. Signature of reparative board of health		90. Signature of reparative board of health	
91. Signature of reparative board of health		92. Signature of reparative board of health		93. Signature of reparative board of health	
94. Signature of reparative board of health		95. Signature of reparative board of health		96. Signature of reparative board of health	
97. Signature of reparative board of health		98. Signature of reparative board of health		99. Signature of reparative board of health	
100. Signature of reparative board of health		101. Signature of reparative board of health		102. Signature of reparative board of health	

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Howard H Holston</b>		2. DATE OF DEATH <b>April 23 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>3411 Noble St</b>		4. USUAL RESIDENCE (Where deceased lived before admission) A. STATE <b>md</b> B. COUNTY <b>Balts</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balts</b>	
C. Length of stay in Baltimore <b>lif</b>		D. STREET ADDRESS (If rural, give location) <b>3411 Noble St</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Feb 23 1898</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Am Buick Co</b>	9. AGE (In years last birthday) <b>72</b>
11. BIRTHPLACE (State or foreign country) <b>Balts</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>John O Holston</b>		14. MOTHER'S MAIDEN NAME <b>Christina Rose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes, no or unknown</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Nellie C Holston</b>		ADDRESS <b>3411 Noble</b>	

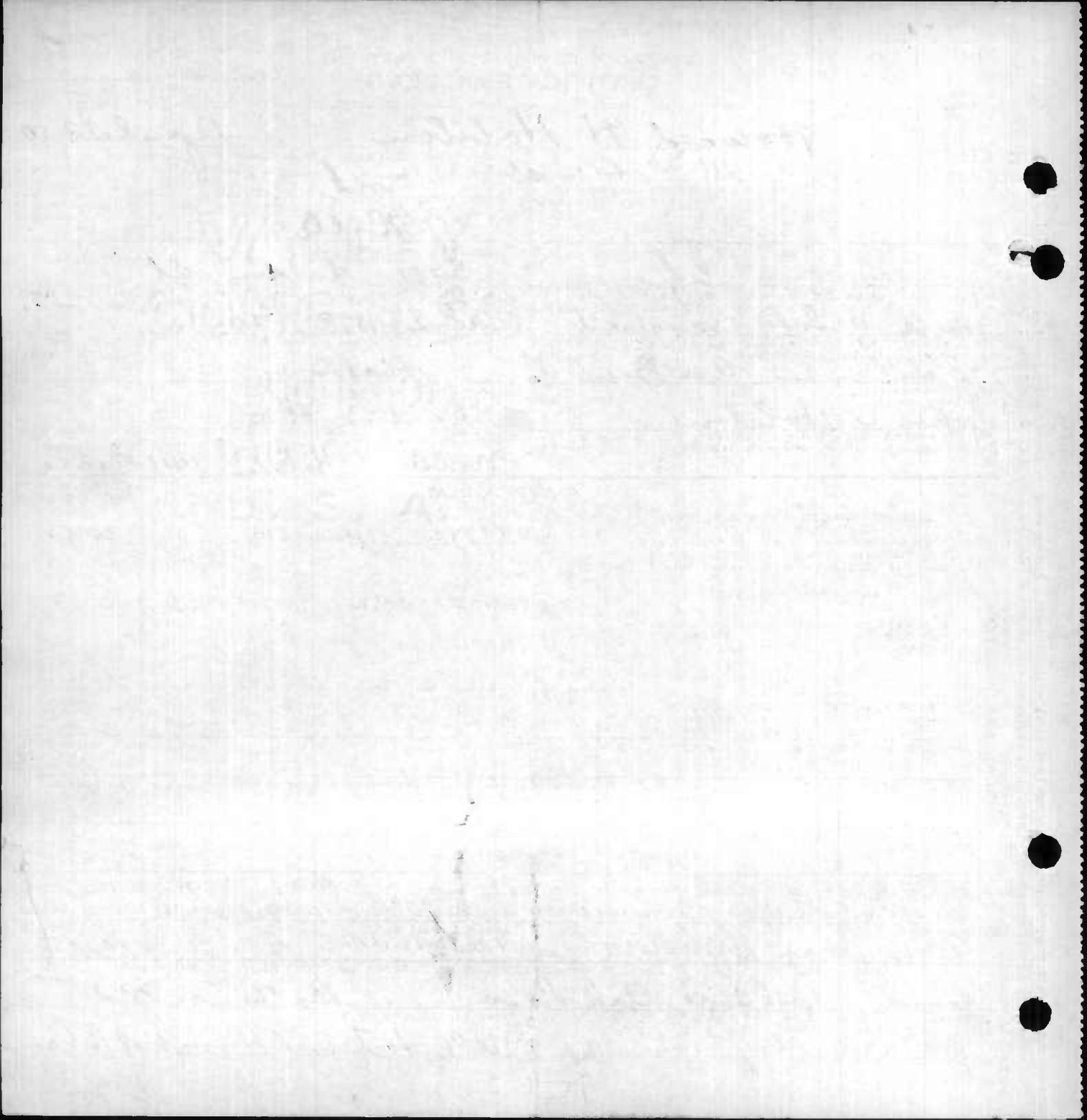
18. <b>332 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>CEREBRAL THROMBOSIS</b> DUE TO (B) <b>ANTERIOSCHEROSIS GENERALIZED</b> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>3 WTS</b>  <b>10 YRS.</b>
---	--	--

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>APRIL 6, 1947</b> , to <b>APRIL 23, 1950</b> , that I last saw the deceased alive on <b>APRIL 22, 1950</b> , and that death occurred at <b>2:05 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Benjamin R. Hyatt</b>		23B. ADDRESS <b>121 S. HILMAN AVE.</b>		23C. DATE SIGNED <b>4/23/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>April 26/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balts Co Md</b>		25. FUNERAL DIRECTOR <b>William H. Williams</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 24 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>William H. Williams</b>			

MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3768

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Baby Girl Dorsey

2. DATE  
OF  
DEATH

Apr. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

202 E. 11th St

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

4-20-50

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Dorsey

14. MOTHER'S MAIDEN NAME

Lee Salubing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

760.5  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Intracranial Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Prematurity

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/20, 1950, to 4/21, 1950, that I last saw the deceased alive on 4/21, 1950, and that death occurred at 7:00 M., from the causes and on the date stated above.

23A. SIGNATURE

G. C. Robinson M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial April 24/50

Glen Haven

Glenburnie Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Huntington, Virginia, M.D.

Ullrich Funeral Home 200 P. O. Box

Child born at home in County.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3769

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Thomas W. Ellis

2. DATE  
OF  
DEATH

4/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MarylandB. COUNTY  
BaltimoreB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

West Baltimore Jail Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

19-04

D. STREET ADDRESS (If rural, give location)

1604 Wilkins Ave

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 23, 1901

9. AGE (In years  
last birthday)

48

10. Under 1 Year

11. Under 24 Hours

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Assist. Supt.

10B. KIND OF BUSINESS OR  
INDUSTRY

Fire Ins. Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Thomas W. Ellis

14. MOTHER'S MAIDEN NAME

Christina Kuhl

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.17. INFORMANT  
Elizabeth Ellis, 1604 Wilkins Ave

ADDRESS

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Acute myocardial infarction

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Arterio sclerosis Coronary  
vascular disease -

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21/50, 1950, to 4/22/50, 1950, that I last saw the  
deceased alive on 4/22, 1950, and that death occurred at 8:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Sara E. Bennett

23B. ADDRESS

W. B. G. Hosp.

23C. DATE SIGNED

4/22/50.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Apr. 25/50

24C. NAME OF CEMETERY OR CREMATORY

Landon Ph.

24D. LOCATION (City, town, or county)

Barto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

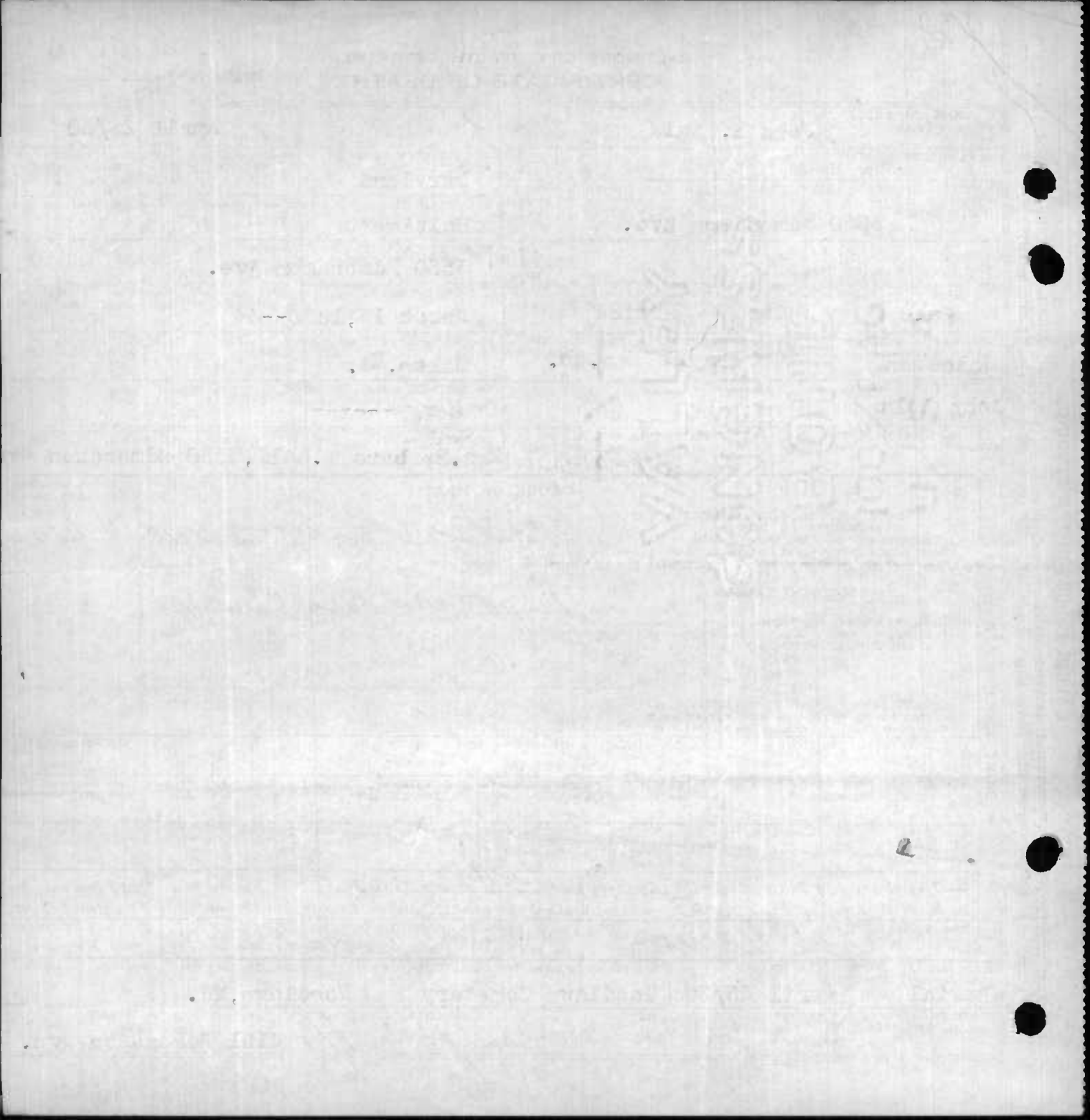
ADDRESS

Harry F. Wight, 4101 Edmondson

APR 24 1950



935



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3771

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Alvah<sup>A.</sup> Jones2. DATE  
OF  
DEATH

4-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

13-04

c. Length of stay in Baltimore

life

O. STREET ADDRESS (If rural, give location)

2827 Parkwood Ave.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 5, 1887

9. AGE (In years  
last birthday)

68 yrs

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Inspector

10B. KIND OF BUSINESS OR  
INDUSTRYBALTO. CITY  
Unknown

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown Victor L. Jones

14. MOTHER'S MAIDEN NAME

Unknown EURITH BARNES

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

A. Evelyn Jones  
(Alvah Jones, Jr.)ADDRESS  
513 (Kodner) Ave.

18. 540.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pneumonia &amp; Renal Failure

DUE TO

ANTECEDENT CAUSES

(B) Perforated Peptic Ulcer

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4-7-50

19B. MAJOR FINDINGS OF OPERATION

Perforated Peptic Ulcer

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-6, 1950 to 4-23, 1950; that I last saw the  
deceased alive on 4/22, 1950, and that death occurred at 5:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Ernest A. Curran

M. D.

23B. ADDRESS

Md. Gent. Hosp.

23C. DATE SIGNED

4/23

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 26/50

24C. NAME OF CEMETERY OR CREMATORY

St. Mary Hampden,

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Harry H. Witzke

25. FUNERAL DIRECTOR

ADDRESS

41016 Edmonds Ave.



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation		Education		Religion		Marital Status	
Physician's Name		Physician's Address		Physician's Signature		Physician's Title		Physician's License No.		Physician's State	
Coroner's Name		Coroner's Address		Coroner's Signature		Coroner's Title		Coroner's License No.		Coroner's State	
Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Signature		Medical Examiner's Title		Medical Examiner's License No.		Medical Examiner's State	
Funeral Home's Name		Funeral Home's Address		Funeral Home's Signature		Funeral Home's Title		Funeral Home's License No.		Funeral Home's State	
Burial Place		Burial Date		Burial Time		Burial Location		Burial Method		Burial Status	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 420-1 50 3772

BIRTH NO. 50 3772

1. NAME OF DECEASED  
(Type or Print)

**Mary Ellen McNeir**

2. DATE OF DEATH **Apr..23, 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE **Md.** B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location)  
**Elmhurst Nursing Home**  
**1708 Eutaw Pl.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

c. Length of stay in Baltimore  
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)  
**25 S. Fulton Ave.**

5. SEX

**Female**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Widow**

8. DATE OF BIRTH

**Sept. 17,**

9. AGE (In years last birthday)

**71**

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY  
**Home**

11. BIRTHPLACE (State or foreign country)  
**Danville, Pa.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Joseph Mottern**

14. MOTHER'S MAIDEN NAME

**Virginia Egeirt**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) (If yes, give war or dates of service)  
**No**

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Mrs. Anna Taylor-Lancaster, Pa.**

18.

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Respiratory Failure**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Myocardial Insufficiency**

DUE TO

**Coronary Occlusion**

(C) **Arteriosclerotic Caedio Vascular Renal Disease**

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 23, 1950** to **Apr. 23, 1950**, that I last saw the deceased alive on **Apr. 20, 1950**, and that death occurred at **11:15AM**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**4/25/50**

24C. NAME OF CEMETERY OR CREMATORY

**Balto. National Cem.**

24D. LOCATION (City, town, or county) (State)

**Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR

**APR 24 1950**

REGISTRAR'S SIGNATURE

*Wm. H. Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

**H.H. Witzke-4101 Edmondson Ave.**

VALLEY

COLEMAN

1911

100

5122

FS-137327

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3773

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Eleanor Hopkins

2. DATE  
OF  
DEATH

4-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1013 N. Vincent St. (17)

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Oct. 6, 1892

9. AGE (in years  
last birthday)

57

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David Blaze

14. MOTHER'S MAIDEN NAME

Mollie Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records\* Balto. City Hospitals Eastern Ave

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease with  
cardiac failure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-15-1950 to 4-20-1950, that I last saw the  
deceased alive on 4-20-1950 and that death occurred at 12:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Crogen

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-22-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. H. Crogen

25. FUNERAL DIRECTOR

Geo. H. Nelson

ADDRESS 1303

Presbyterian

Received of the  
 Treasurer of the  
 Board of Education  
 the sum of \$100.00  
 for the year 1903.  
 J. H. [Signature]  
 1903

F-652  
MS--137378

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3774

BIRTH NO. 50 3774

1. NAME OF DECEASED (Type or Print) <b>(Toye Russell)</b> <b>Florine French</b>		2. DATE OF DEATH <b>4-23-50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>31 Baltimore City Hospitals</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-02</b>	
c. Length of stay in Baltimore <b>life</b>		D. STREET ADDRESS (If rural, give location) <b>1935 W. North Ave.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 14, 1910</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>39</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Toy (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Russell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Baltimore City Hospitals Records* 4940 Eastern Ave.</b>		ADDRESS	

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>C</b> <b>Hypertensive Cardiovascular Disease</b> DUE TO <b>(B) NEPHROSCLEROSIS</b> <b>A UREMIA</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic Glomerulonephritis</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <b>(OVER)</b>
	ANTECEDENT CAUSES	
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	

19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-17-</b> , 19 <b>50</b> , to <b>4-23-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-23-</b> , 19 <b>50</b> , and that death occurred at <b>4:53A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>4-24-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/26/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>Geo. S. Nelson 1323 Broadway</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 24 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEE DOCUMENT FILE JO-3774  
FOR AMENDMENT

9-14-50

32083-50



CERTIFICATE CORRECTED 5-2-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3775  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES A. PLUMLY

2. DATE  
OF  
DEATH

April, 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)Anderson Nursing Home  
3604 Mohawk Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-04

D. STREET ADDRESS (If rural, give location)

formerly of 5101 Brook Green Rd. (Ten Hills)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1876  
Oct. 15, (1877)9. AGE (In years  
last birthday)

(72) 73

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Supt. of Telegraph

10B. KIND OF BUSINESS OR  
INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Borden Plumly

14. MOTHER'S MAIDEN NAME

Ann Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. H. D. Plumly 1325 E. 35th St.

18. 260 X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) Cardiac decomp  
DUE TO Arteriosclerotic Hypertensive  
(B) Cardio-vascular disease  
DUE TO  
(C) Diabetes mellitusINTERVAL BETWEEN  
ONSET AND DEATH

5 days

6 yrs

12 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 13, 1950, to Apr. 22, 1950, that I last saw the deceased alive on Apr. 22, 1950, and that death occurred at 6 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas L. Todd M. D.

23B. ADDRESS

2108 St Paul St

23C. DATE SIGNED

4/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.  
156 47

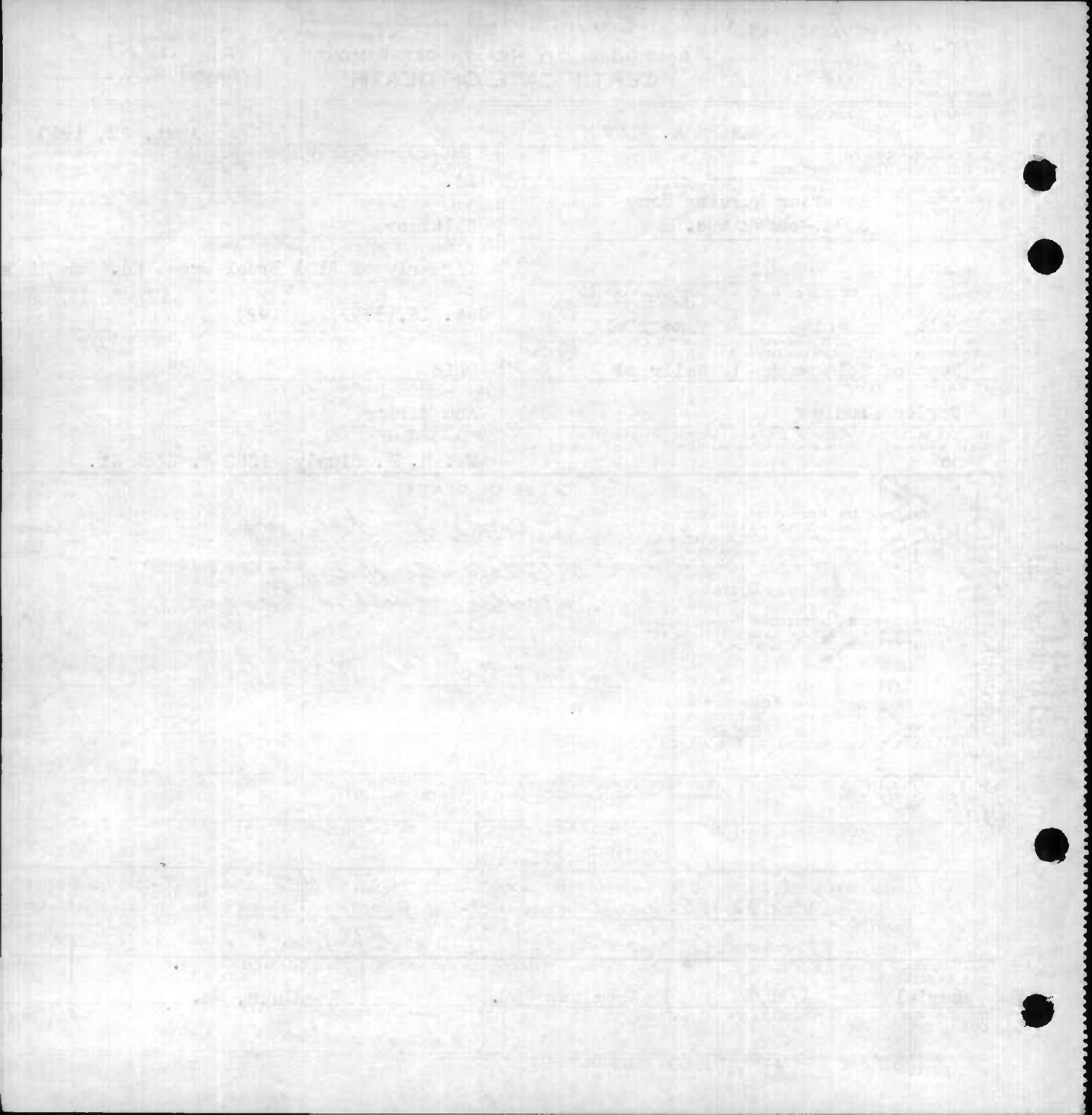
25. FUNERAL DIRECTOR

Wm. J. Lickner &amp; Sons Balto Md

ADDRESS

APR 24 1950

61



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be legibly and correctly stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3776  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MILDRED HARDY DORSEY

2. DATE  
OF  
DEATH

Apr. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 12-02

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION  
2903 N. Calvert St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2903 N. Calvert St.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

June 17, 1905

9. AGE (In years last birthday)

44

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James M. Hardy

14. MOTHER'S MAIDEN NAME

-- Bartee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Charles A. Dorsey 2903 N. Calvert St

18.

260 X

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 day

since 1939

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

✓

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

✓

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

✓

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

✓

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

✓

22. I hereby certify that I attended the deceased from Nov 7, 1947, to Apr 22, 1950, that I last saw the deceased alive on Apr 22, 1950, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

*E. McGeehan*

M. D.

23B. ADDRESS

705 Med Oak Rd

23C. DATE SIGNED

Apr 24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 24 1950

REGISTRAR'S SIGNATURE

*W. H. Williams, M.D.*

25. FUNERAL DIRECTOR

*Wm. J. Bickner & Sons*

ADDRESS

Balto Md.

RECEIVED BY THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

ATTESTED BY THE DEPARTMENT OF HEALTH

1901 - 1902

1901 - 1902

1901 - 1902

1901 - 1902

1901 - 1902

1901 - 1902

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1901 - 1902

1901 - 1902

1901 - 1902

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3777BIRTH NO. 50 37771. NAME OF DECEASED  
(Type or Print)

JOHN GRASON WISNER

2. DATE  
OF  
DEATH

Apr. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

909 Woodbourne Ave.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE 909 Woodbourne Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Sept. 14, 1880

9. AGE (In years  
last birthday)

69

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Owner

10B. KIND OF BUSINESS OR  
INDUSTRY  
Storage garage  
& filling station

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William N. Wisner

14. MOTHER'S MAIDEN NAME

Martha Ellen Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

Mr. Harry W. Wisner

ADDRESS

Pikesville  
135 Slade Ave.

18.

331X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Cerebral hemorrhage

20 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Arterial hypertension

2 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Partial rth Hemiplegia

5 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from Sept 9, 1948, to Apr 22, 1950, that I last saw the  
deceased alive on Apr 22, 1950, and that death occurred at 4:40 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Frederick D. Tollmer

M. D.

23B. ADDRESS

6100 York Road

23C. DATE SIGNED

Apr 24, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Pickner &amp; Sons Balto Md

APR 24 1950

15684

83a



DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment		18. Signature of cremation		19. Signature of other		20. Signature of other	
21. Signature of other		22. Signature of other		23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	



S-425

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3778  
Registered No.

BIRTH NO.

50 3778

1. NAME OF DECEASED  
(Type or Print)

Mary M. Schlesinger

2. DATE  
OF  
DEATH

Apr. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-05

D. STREET ADDRESS (If rural, give location)

2532 Wilkens Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

12-8-1865

9. AGE (In years last birthday)

84

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Renner - Renner

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Anna C. Ebberts

ADDRESS

- Same -

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Dilatation of Heart

DUE TO

About 5 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Disease

DUE TO

Old Age

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from January 17, 1950, to April 21, 1950, that I last saw the deceased alive on April 19, 1950, and that death occurred at 1:15 p. m., from the causes and on the date stated above.

23. SIGNATURE

Anna C. Ebberts

M. D.

23A. ADDRESS

516 Cathedral St.

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Washington Williams, M.D.

F. C. Whippert, Sr. - 1200 E. ...

937

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

TIME

PLACE OF DEATH

C-600

50 3779

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3779

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Kysar J. Carey

2. DATE  
OF  
DEATH

Apr 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Bethesda

D. STREET ADDRESS (If rural, give location)

4439 Cordell Ave

c. Length of stay in Baltimore

2 Mos. Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL ADDRESS

18. 151X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Stomach, Carcinoma of 26 mos

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 4/16 1950 to 4/23 1950, that I last saw the  
deceased alive on 4/23 1950, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

J. C. Vandell Jr

M. O.

JOHNS HOPKINS HOSPITAL

4/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Removal

24 APR 50

Bethesda

Md. Bethesda Md.

APR 24 1950

William H. Williams

Robert H. Humphrey - Bethesda

Md.

308 V9

46B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

\_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**CERTIFICATE CORRECTED**

4-24-50

DiCRISPINO

50 3780

BALTIMORE CITY HEALTH DEPARTMENT

**CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

Salvatore

1. NAME OF DECEASED  
(Type or Print)

Mr. Salvatore DiCrispino, Jr.

2. DATE  
OF  
DEATH

4/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Church Home + Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15 15-16

D. STREET ADDRESS (If rural, give location)

2701 Keyworth Ave.

c. Length of stay in Baltimore

life 49

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

W.S.

8. DATE OF BIRTH 1900 9. AGE (In years last birthday) 50-49

July 31, 1899

10 Under 1 Year 11 Under 24 Hours

Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

GROCERY (R)

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Salvatore DiCrispino

14. MOTHER'S MAIDEN NAME

Josephine Zito

Josephine Zito

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or oookoonn) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Mr. Frank DiCrispino 2703 Keyworth Ave.

18.

420.1

**CAUSE OF DEATH**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH

2 days

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Generalized Arteriosclerosis

yes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diverticulosis

yes

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/20 10AM, 1950, to 4/20, 1950, that I last saw the deceased alive on 4/20, 1950 and that death occurred at 5:35 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Ennor

M. D.

23B. ADDRESS

Church Home + Hosp.

23C. DATE SIGNED

4/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

Apr. 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

4611 Park Heights Ave.

APR 25 1950

29861

94a







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3781  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Margaret Theresa Miller,

2. DATE OF DEATH  
April 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

8. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

5119 Woolverton Ave.,

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore,

D. STREET ADDRESS (If rural, give location)  
5119 Woolverton Ave.

c. Length of stay in Baltimore

life

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

June 28, 1876

9. AGE (In years last birthday)

73

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William Joseph Miller,

14. MOTHER'S MAIDEN NAME

Mary Ann McNamara.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
no

16. SOCIAL SECURITY NO.  
none

17. INFORMANT ADDRESS  
Miss N.E. Miller, 5119 Woolverton Ave.

18. 332X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral embolus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Arterio. sclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 24, 1950, to April 22, 1950, that I last saw the deceased alive on April 21, 1950, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

OFFICE OF THE ATTORNEY GENERAL

IN SENATE

REPORT

OF THE

COMMISSIONER

OF THE LAND OFFICE

FOR THE YEAR 1900

ALBANY:

1901

PRINTED BY

THE STATE

PRINTING OFFICE

ALBANY

1901

NEW YORK

1901

1901

1901

1901

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 3782

BIRTH NO. 3782

1. NAME OF DECEASED (Type or Print) <u>Florence Sturgeon</u>			2. DATE OF DEATH <u>4/22/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>634 Wook Blvd</u> B. COUNTY <u>Bolts md</u>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Ashburton Nursing Home</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Bolts md</u>		
c. Length of stay in Baltimore <u>Life</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>22-02</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>August Sturgeon</u>	8. DATE OF BIRTH <u>Dec 6 1874</u>		9. AGE (in years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired A.W.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>
13. FATHER'S NAME <u>William Mitchell</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Harrison</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Charles A Sturgeon 2037 GRINNARDS</u>		

18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Cardiac Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 da</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Generally of Arterio Sclerotic Cardiovascular Disease</u>		<u>532</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>3/10</u> 19 <u>50</u> , to <u>4/22</u> 19 <u>50</u> , that I last saw the deceased alive on <u>4/22</u> 19 <u>50</u> , and that death occurred at <u>9:10 pm.</u> , from the causes and on the date stated above.		
23A. SIGNATURE <u>Joseph B. Laukaitis</u>	23B. ADDRESS <u>675 Westington Blvd</u>	23C. DATE SIGNED <u>4/24/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/25/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Towclaw Park</u>
24D. LOCATION (City, town, or county) <u>Friedrich Rd</u>		(State)
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 24 1950</u>	REGISTRAR'S SIGNATURE <u>Wilmington Williams, MD</u>	25. FUNERAL DIRECTOR <u>Chas P. Towell</u>
VS 150		ADDRESS <u>2457 Edmondson Ave</u>

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Sankita  
179 Wash Blvd  
SA 0772  
Q# 2080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

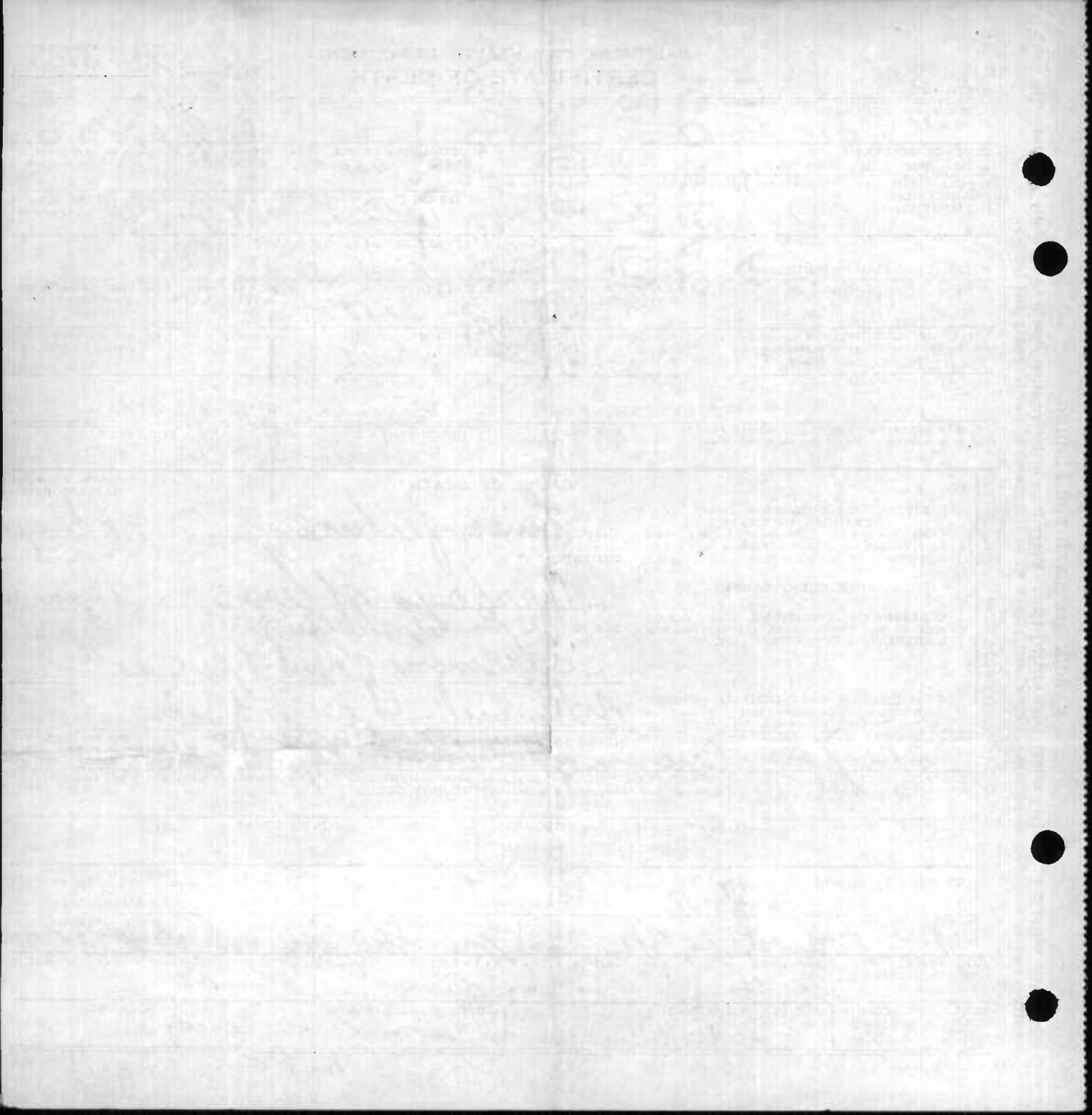
 Registered No. **50 3783**

 BIRTH NO. **50 3783**

1. NAME OF DECEASED (Type or Print) <b>Rose Fontz</b>			2. DATE OF DEATH <b>4/22/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Tr. Sg. Hosp.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Ba. 24-04</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural give location) <b>1511 Byron Rd.</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W.</b>	B. DATE OF BIRTH <b>9/1/1882</b>		9. AGE (In years last birthday) <b>67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>House</b>		11. BIRTHPLACE (State or foreign country) <b>Ba.</b>
13. FATHER'S NAME <b>Leo. Waslengeest</b>			14. MOTHER'S MAIDEN NAME <b>Rutha Metzger</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, so on unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Tammy - Jones</b>

18. <b>157 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Liver failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cirrhosis of liver &amp; portal obstruction</b>			(B) <b>2 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma of head of pancreas?</b>			(C) <b>Arteriosclerotic heart disease</b>		
19A. DATE OF OPERATION <b>4/21/50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of head of pancreas &amp; portal obstruction</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/24/50</b> to <b>4/22/50</b> , that I last saw the deceased alive on <b>4/22/50</b> , and that death occurred at <b>2:30 p. m.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>J. F. Hawkins, Jr.</b>		23B. ADDRESS <b>Franklin Square Bldg.</b>		23C. DATE SIGNED <b>4/22/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B.</b>		24B. DATE <b>4-15-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Ba.</b>		25. FUNERAL DIRECTOR <b>James H. McLeary</b>		ADDRESS <b>130 S. Fort Ave.</b>	







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

August Ott

2. DATE  
OF  
DEATH

4/20/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

Life

O. STREET ADDRESS (If rural, give location)

none Linden Avenue?

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 16, 1876

9. AGE (In years last birthday)

73

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None STEWARD

10B. KIND OF BUSINESS OR INDUSTRY

WATER TRANSPORT

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

Marie Gibbs Miami, Fla.

18. 422.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebrovascular accident

ONE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic cardiovascular disease

ONE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10, 1950, to 4-20, 1950, that I last saw the deceased alive on 4/20, 1950, and that death occurred at 7:35 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Marquise Louisa Cardew

M. O.

23B. ADDRESS

Md. General Hospital

23C. DATE SIGNED

4/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

Balto. Co. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

J.T. Stansbury 2700 Edmondson Ave.

Lon 3470

MAC 11

IF CASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3785

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES H. THOMPSON

2. DATE  
OF  
DEATH

4/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

23-01

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1041 S. Sharp Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

4/5/1896

9. AGE (In years last birthday)

54

10 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Chemical Plant

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles Thompson

14. MOTHER'S MAIDEN NAME

Madeline Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

Yes

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

W. W. 1.

215-07-4100

17. INFORMANT

Mary Matthews - Sharp St

1041 ADDRESS

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Essential hypertension

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/22/50, to 4/22/50, that I last saw the deceased alive on 4/22/50, and that death occurred at 6 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Harry G. Yezjian M. D.

23B. ADDRESS

1213

23C. DATE SIGNED

Right Street 4/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/22/50

24C. NAME OF CEMETERY OR CREMATORY

Balt National

24D. LOCATION (City, town, or county) (State)

Balt City

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. L. Brown &amp; Son - Montgomery St

108-W ADDRESS

STATE OF NEW YORK  
CERTIFICATE OF DEATH

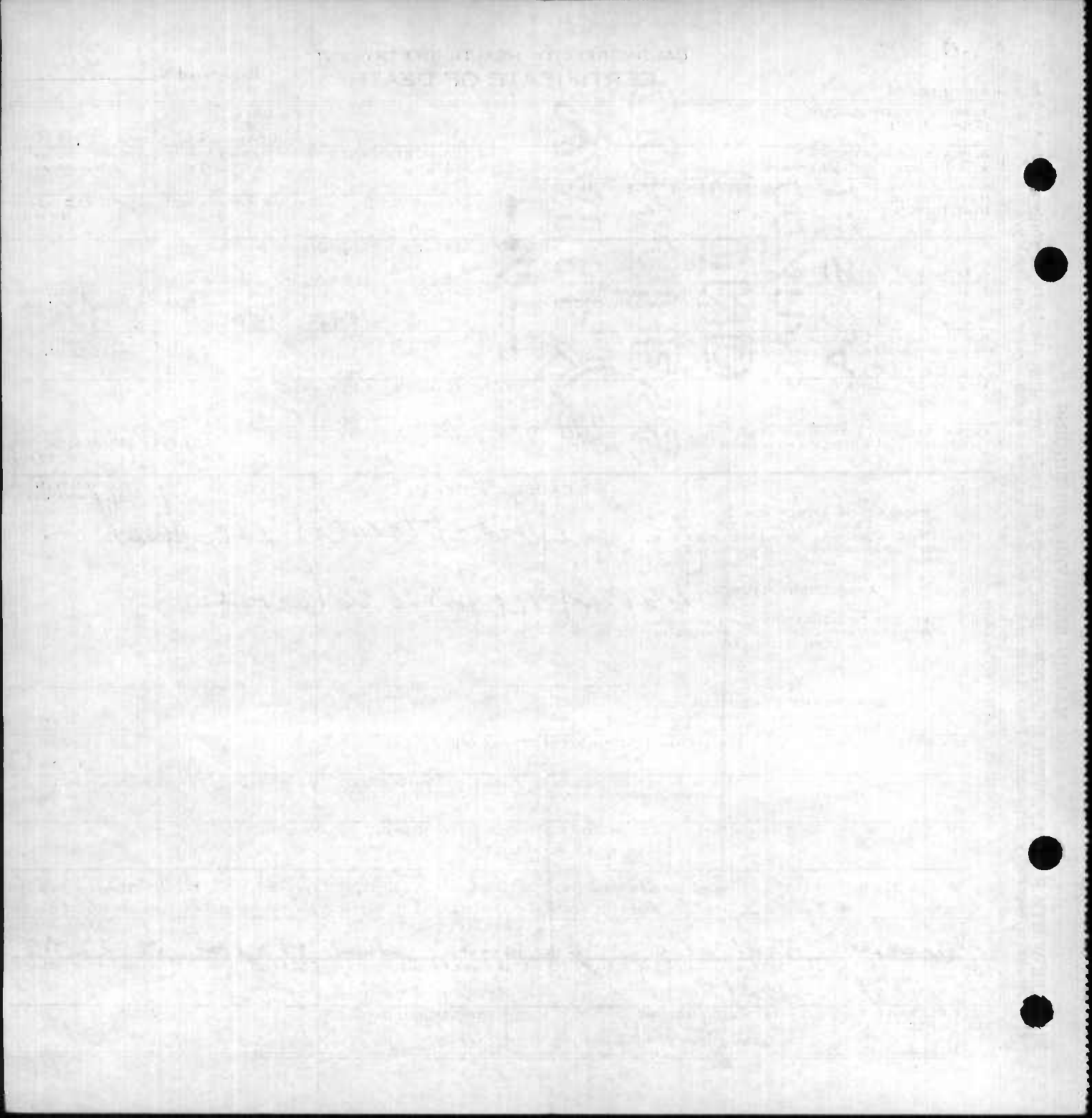
37

STATE OF NEW YORK

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3786M-633  
BIRTH NO. 50 3786

1. NAME OF DECEASED (Type or Print) <u>Mary Estelle Meredith (Miss)</u>			2. DATE OF DEATH <u>April 21, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
C. Length of stay in Baltimore <u>44</u> Yrs. <u>44</u> Mos. <u>44</u> Days			D. STREET ADDRESS (If rural, give location) <u>106 W. University Pkwy.</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 5, 1890</u>	9. AGE (In years, last birthday) <u>59</u>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Meredith</u>			14. MOTHER'S MAIDEN NAME <u>Clara Virginia Denison</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>106 W. University Pkwy.</u>		
17. INFORMANT <u>[Sister] Miss Elizabeth Meredith</u>			18. CAUSE OF DEATH <u>Cerebro-vascular accident</u> <u>marked as per Dr. [illegible]</u>		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO <u>marked as per Dr. [illegible]</u>			INTERVAL BETWEEN ONSET AND DEATH		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>marked as per Dr. [illegible]</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
21. DATE OF OPERATION <u>0</u>			22. MAJOR FINDINGS OF OPERATION		
23. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			24. DATE OF OPERATION		
25. ACCIDENT, SUICIDE, HOMICIDE (Specify)		26. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME (Month) (Day) (Year) (Hour) OF INJURY		29. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30. HOW DID INJURY OCCUR?	
31. I hereby certify that I attended the deceased from <u>April 21, 1950</u> , to <u>April 21, 1950</u> , that I last saw the deceased alive on <u>April 21, 1950</u> , and that death occurred at <u>8:30 p.m.</u> , from the causes and on the date stated above.					
32. SIGNATURE <u>Marshall [illegible]</u>		33. ADDRESS <u>M. D. [illegible]</u>		34. DATE SIGNED <u>4-22-50</u>	
35. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		36. DATE <u>4/25/50</u>		37. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	
38. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		39. DATE RECEIVED BY LOCAL REGISTRAR <u>APR 24 1950</u>		40. REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>	
41. FUNERAL DIRECTOR <u>Wm. J. [illegible]</u>		42. ADDRESS <u>106 W. University Pkwy.</u>		43. SIGNATURE <u>[illegible]</u>	







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Charles Everett Wood*

2. DATE  
OF  
DEATH

*4/23/50.*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

*Maryland General Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*632 Washington Blvd.*

c. Length of stay in Baltimore

*Life.*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED,

*WIDOWED, DIVORCED (Specify)*

8. DATE OF BIRTH

*April 1, 1880*

9. AGE (In years last birthday)

*70.*

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Retired Battalion Chief*

10B. KIND OF BUSINESS OR INDUSTRY

*Fire Dept. City*

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*John Gustavus Wood*

14. MOTHER'S MAIDEN NAME

*Mary E. King*

15. WAS DECEASED EVER IN U.S.-ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*none*

17. INFORMANT ADDRESS

*Miss Norma E. Wood - 632 Wash. Blvd.*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Acute Myocardial Infarct - 2 days*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *tion & shock.*

DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 23, 1950*, to *April 23, 1950*, that I last saw the deceased alive on *April 23, 1950* and that death occurred at *9:50 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Belda L. Tucker*

23B. ADDRESS

*Maryland Gen. Hosp.*

23C. DATE SIGNED

*4/23/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*4/26/50*

24C. NAME OF CEMETERY OR CREMATORY

*Wood Ridge Cem.*

24D. LOCATION (City, town, or county)

*Pikesville, Md.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Washington Williams, M.D.*

25. FUNERAL DIRECTOR

*Wm. J. Pickner & Sons - Balto Md.*

ADDRESS

APR 24 1950

VS 150

600 98

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
OFFICE OF THE COMMISSIONER  
ALBANY, N. Y.

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 3788

BIRTH NO. 50 3788

1. NAME OF DECEASED (Type or Print) <u>Elizabeth Batz</u>			2. DATE OF DEATH <u>4-23-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>3138 Foster Ave.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto - 24 Md 1-02</u>		
C. Length of stay in Baltimore <u>Life</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>3138 Foster Ave</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug-6-1857</u>		9. AGE (In years last birthday) <u>92</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Hilderbrandt</u>			14. MOTHER'S MAIDEN NAME <u>Anna ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT ADDRESS <u>Anna Kramer 3138 Foster Ave. Balto.</u>		

18. <u>332X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Arterio-sclerosis Arteriosclerosis</u> DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/16</u> , 19 <u>50</u> , to <u>4/23</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>50</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Charles Hilderbrandt</u>		23B. ADDRESS <u>3123 Eastern Ave</u>		23C. DATE SIGNED <u>4/24/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-26-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Cath. Lawn</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 24 1950</u>		REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>		25. FUNERAL DIRECTOR ADDRESS <u>Lilly + Zick, 403 S. Wolfe St</u>	

VS 150

83B

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for accuracy. The age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Flom -

3123 Oak Ave

①

Dr. Kew.

2529 Eastern Ave. ①

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 3789

BIRTH NO. 50 3789

1. NAME OF DECEASED (Type or Print) <u>Michael Zaworski</u>			2. DATE OF DEATH <u>4-19-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1-03</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>520 S. Lakewood Ave</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto., Md.</u>		
c. Length of stay in Baltimore <u>60 years</u>			D. STREET ADDRESS (If rural, give location) <u>520 S. Lakewood Avenue</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1-25-74</u>	9. AGE (in years last birthday) <u>76</u>	10. Under 1 Year Months: Days <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brass Finisher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>McShane Co</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT ADDRESS <u>Mrs Helen Chase- 520 S. Lakewood Avenue</u>	

18. <u>151X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Stomach</u> DUE TO (A) <u>Carcinoma of Stomach</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C) <u>II</u>			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 30, 1950</u> , to <u>April 19, 1950</u> , that I last saw the deceased alive on <u>April 18, 1950</u> , and that death occurred at <u>m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <u>Andrew Kunkowski</u>		23B. ADDRESS <u>2529 Eastern av.</u>	23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-24-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 24 1950</u>		25. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Zeiler, Inc 403 S. Wolfe Street</u>	

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3750

Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AGNES ROLLISON

2. DATE  
OF  
DEATH

APRIL 23 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

1561 CARSWELL ST.

c. Length of stay in Baltimore

25 yrs.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

SEPT 23 1898

9. AGE (In years  
last birthday)

51

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SEAMSTRESS

10B. KIND OF BUSINESS OR  
INDUSTRY

CLOTHING FACTORY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

HERMAN EHOFF.

14. MOTHER'S MAIDEN NAME

MINNIE STANIG

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

212-09-3698

17. INFORMANT

ADDRESS

18.

442X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

UREMIA.

(A)

DUE TO

3 DAYS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

ARTERIOLAR NEPHROSCLEROSIS

(B)

NOT  
KNOWN.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ESS. HYPERTENSION. CARDIOVASCULAR D. NOT KNOWN.

CONGESTIVE HEART FAILURE

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL 18, 1950 to APRIL 23, 1950, that I last saw the  
deceased alive on APRIL 22, 1950, and that death occurred at 3:30 AM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

Huntington Williams, M.D.

Philip Herwig Sons

Orleans

VS 150

49606

1312 St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for accuracy and legibility. The age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles Schaub

2. DATE  
OF  
DEATH

April 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

4-10-1884

9. AGE (in years  
last birthday)

66

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR  
INDUSTRYWORKED FOR  
BUILDING CONTRACTOR

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Schaub

14. MOTHER'S MAIDEN NAME

Mary Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
216-07-1466

17. INFORMANT

Rose Schaub

ADDRESS

Same

18. 4221

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Congestive heart failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic CVD

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Cystic disease of the lungs, bilateral

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/19, 1950, to 4/22, 1950, that I last saw the  
deceased alive on 4/22, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. J. P. Nichols

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Baltimore, Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Easton Sons Catonsville Md.

ADDRESS

APR 24 1950

30FV9

937

1948 63

6-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3792  
Registered No. \_\_\_\_\_

H-341  
50 3792  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mrs. Florence Grace Heidelberg</b>			2. DATE OF DEATH <b>4-20-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Women's Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Catonsville 5300</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1205 Frederick Rd.</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11-27-87</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. W.</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Eugene Cook</b>			14. MOTHER'S MAIDEN NAME <b>Markley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>William Jacob Heidelberg</b>		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>1. V3X I</b>	CAUSE OF DEATH <b>1205 Frederick Ave</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>	(A) <b>Hematemesis</b> DUE TO (B) <b>(ascending) adenocarcinoma of colon + abdominal metastasis</b> DUE TO (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-20-50</b> , 19__, to <b>4-20-50</b> , 19__, that I last saw the deceased alive on <b>4-20-50</b> , 19__, and that death occurred at <b>10 P</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>H.C. Decker</b>		23B. ADDRESS <b>Women's Hospital</b>		23C. DATE SIGNED <b>4-20-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Soudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>		25. FUNERAL DIRECTOR <b>Marie Cook Syfer</b>		ADDRESS <b>1600 West North Ave #6E</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 24 1950</b>		REGISTRAR'S SIGNATURE <b>Marion Williams, M.D.</b>			







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3793  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Harry D.

WALCK

2. DATE  
OF DEATH April 21, 19503. PLACE OF DEATH:  
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BaltimoreD. STREET ADDRESS (If rural, give location)  
1615 Holmestead St.

c. Length of stay in Baltimore

2 YRS:

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER-

10B. KIND OF BUSINESS OR INDUSTRY

FURNITURE

8. DATE OF BIRTH

Nov-26-24

9. AGE (In years last birthday)

25

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

GREENCASTLE PA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

JOHN E. WALCK SR.

14. MOTHER'S MAIDEN NAME

ELSIE M. BURKET

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

YES

#2 - 1942 To 45

16. SOCIAL SECURITY NO.

106-22-6298

17. INFORMANT

JOHN WALCK 908 BONAPARTE

ADDRESS

18. E971.8

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cyanide poisoning

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1615 Holmestead St.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

April 21, 1950 7:30 P.M.

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

WORK ☐AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of cyanide

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

RST-roler

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
April 22, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

APRIL 26-50

24C. NAME OF CEMETERY OR CREMATORY

BALTO-NATIONAL

24D. LOCATION (City, town, or county) (State)

BALTO-MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Eesworth Amacost 1639

VS 151

N-979.0

98867

5118 Suryn Oak Ave. ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF TEXAS  
COUNTY OF DALLAS

10

11

12

13

14

15

16

17

18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

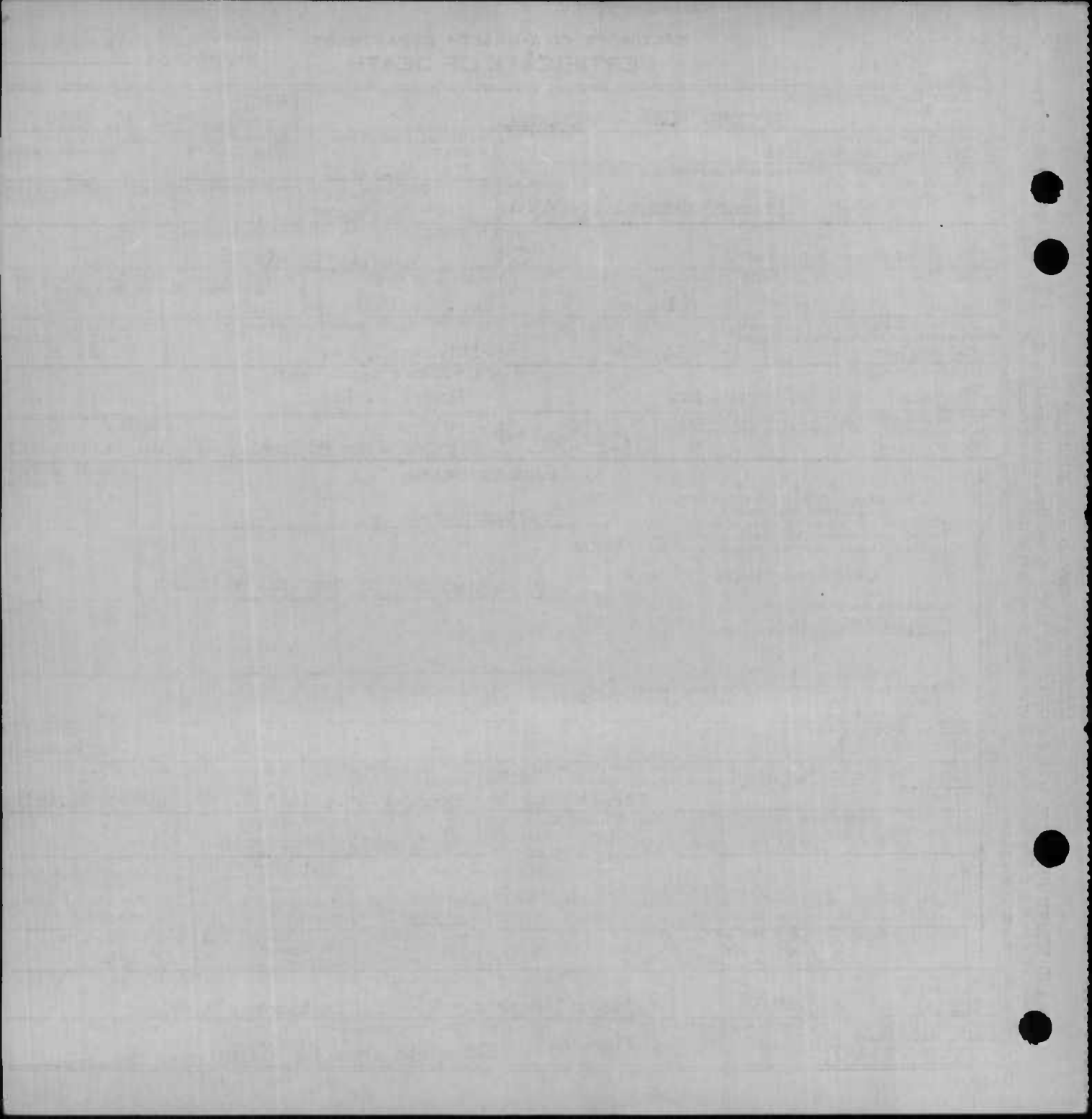
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3794  
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
RAYMOND JOHN MUNGOVAN		April 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-10	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 4101 Dorchester Road	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 3, 1931
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolboy		10B. KIND OF BUSINESS OR INDUSTRY Loyola	9. AGE (In years last birthday) 19
11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Raymond John Mungovan, Sr.		14. MOTHER'S MAIDEN NAME Gladys L. Lauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-28-0513	
17. INFORMANT Raymond John Mungovan, Sr.		ADDRESS 4101 Dorchester	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fractured neck ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Dislocation of 7th cervical vertebra OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office Bldg., etc.) Street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hanover St., 144' S. of Hanover St. Bridge		21D. TIME (Month) (Day) (Year) (Hour) 4/24/50 12:30 A. m.	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Automobile into pole	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE R. S. Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>	
23C. DATE SIGNED 4/24/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/50	
24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25. FUNERAL DIRECTOR Ellsworth Amacost		ADDRESS 5118 Gwynn Oak Ave.	

N-805.2

170c



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3795  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Patricia Jane Glass A 77603

2. DATE  
OF  
DEATH

APR 24 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

West Orange  
125 Northfield Ave.

c. Length of stay in Baltimore

one day

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

child

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

East Orange, N. J.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Raymond Glass

14. MOTHER'S MAIDEN NAME

Rosalie Fusara

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

754.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cong. Ht. Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Cong. Mitral Stenosis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Coarctation of the Aorta

INTERVAL BETWEEN ONSET AND DEATH

7 1/2  
Life

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4-23-1950 to 4-24-1950, that I last saw the deceased alive on 4-24-1950, and that death occurred at 1234 Am., from the causes and on the date stated above.

23A. SIGNATURE

Harrison C. Spencer

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/25/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county)

4430 Belair Rd. Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

2601-3-5 E. Madison St.

ADDRESS

Charles E. Schimunek Pres.  
157E

APR 24 1950





50 3796

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3796  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jennie Lloyd

2. DATE  
OF  
DEATH

4/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

South Baltimore General Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Pikesville

5300

D. STREET ADDRESS (If rural, give location)

McHenry Lane

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/11

9. AGE (In years last birthday)

70

10 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Andrew Marks

14. MOTHER'S MAIDEN NAME

Mary Blum

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

John Lloyd, Pikesville, Md

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL EMBOLISM

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE VASCULAR DISEASE

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

22. I hereby certify that I attended the deceased from 4/18/50, 19, to 4/23/50, 19, that I last saw the deceased alive on 4/23, 1950, and that death occurred at 12:45A.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 24 1950

937 2nd

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

IN SENATE  
January 1, 1913  
REPORT  
OF THE  
COMMISSIONER OF HEALTH  
FOR THE YEAR  
1912

ALBANY:  
J. B. LIPPINCOTT COMPANY  
1913

PRINTED BY  
J. B. LIPPINCOTT COMPANY  
ALBANY, N. Y.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)*Edmund C. Poole*2. DATE  
OF  
DEATH*April 22, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *2409 Md. Ave.*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE *Maryland* B. COUNTY *Hartford*B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Rural-- Joppa 6200*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days  
*7*

D. STREET ADDRESS (If rural, give location)

5. SEX

*male*

6. COLOR OR RACE

*white*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
*widowed*

8. DATE OF BIRTH

*6-14-1874*9. AGE (In years  
last birthday)*75*If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Caretaker*10B. KIND OF BUSINESS OR  
INDUSTRY*Estate*

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF  
WHAT COUNTRY?*U.S.*

13. FATHER'S NAME

*William H. Poole*

14. MOTHER'S MAIDEN NAME

*Katherine Mealey*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*no*16. SOCIAL  
SECURITY NO.*--*17. INFORMANT ADDRESS  
*Mrs. Albert Hobson, 2409 Md. Ave*18. *420.1*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Coronary Thrombosis,*  
*Posterior Coronary artery*INTERVAL BETWEEN  
ONSET AND DEATH*7 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *Arteriosclerosis*

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

*Sev. years*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 15*, 1950, to *April 22*, 1950, that I last saw the  
deceased alive on *April 21*, 1950, and that death occurred at *2:40 Pm.*, from the causes and on the date stated above.

23A. SIGNATURE

*E. Ellsworth Poole M.D.*

23B. ADDRESS

*2431 Maryland Ave*

23C. DATE SIGNED

*4-22-50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*BURIAL*

24B. DATE

*4-25-1950*

24C. NAME OF CEMETERY

*Linganore*

24D. LOCATION (City, town, or county) (State)

*Unionville, Fred Co. Md.*DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*G.M. Waltz, Winfield Md.*

DATE OF DEATH

1. NAME (Last, First, Middle Initial)

2. DATE OF BIRTH

3. PLACE OF BIRTH

4. OCCUPATION

5. EDUCATION

6. MARITAL STATUS

7. RELIGION

8. RACE

9. SEX

10. HEIGHT

11. WEIGHT

12. HAIR COLOR

13. EYE COLOR

14. SKIN COLOR

15. BLOOD TYPE

16. SOCIAL SECURITY NUMBER

17. DATE OF DEATH

18. PLACE OF DEATH

19. CAUSE OF DEATH

20. SIGNATURE

M-650

50 3798

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3798

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Francis Le Roy Moran

2. DATE  
OF  
DEATH4/24/50 10<sup>30</sup> a.m.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

00 2045 Kennedy Ave

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)  
Balto. 9-08

D. STREET ADDRESS (If rural, give location)

2045 Kennedy Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10/2/1897

9. AGE (in years last birthday)

52

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Private Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

John H. Eusey

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John A. Moran

14. MOTHER'S MAIDEN NAME

Mary A. Eagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary B. Moran 2045 Kennedy Ave

18.

416 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) .....  
DUE TO

Rheumatic Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....  
DUE TO  
(C) .....

INTERVAL BETWEEN ONSET AND DEATH

?

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/30, 1950, to 4/24, 1950, that I last saw the deceased alive on 4/23, 1950, and that death occurred at 10<sup>30</sup> a.m., from the causes and on the date stated above.

23A. SIGNATURE

Lacee L. Green, D.

23B. ADDRESS

1761 E Mtz Ave

23C. DATE SIGNED

4/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

St. Josephs

24D. LOCATION (City, town, or county) (State)

Texas Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Lutington Williams, M.D.

25. FUNERAL DIRECTOR

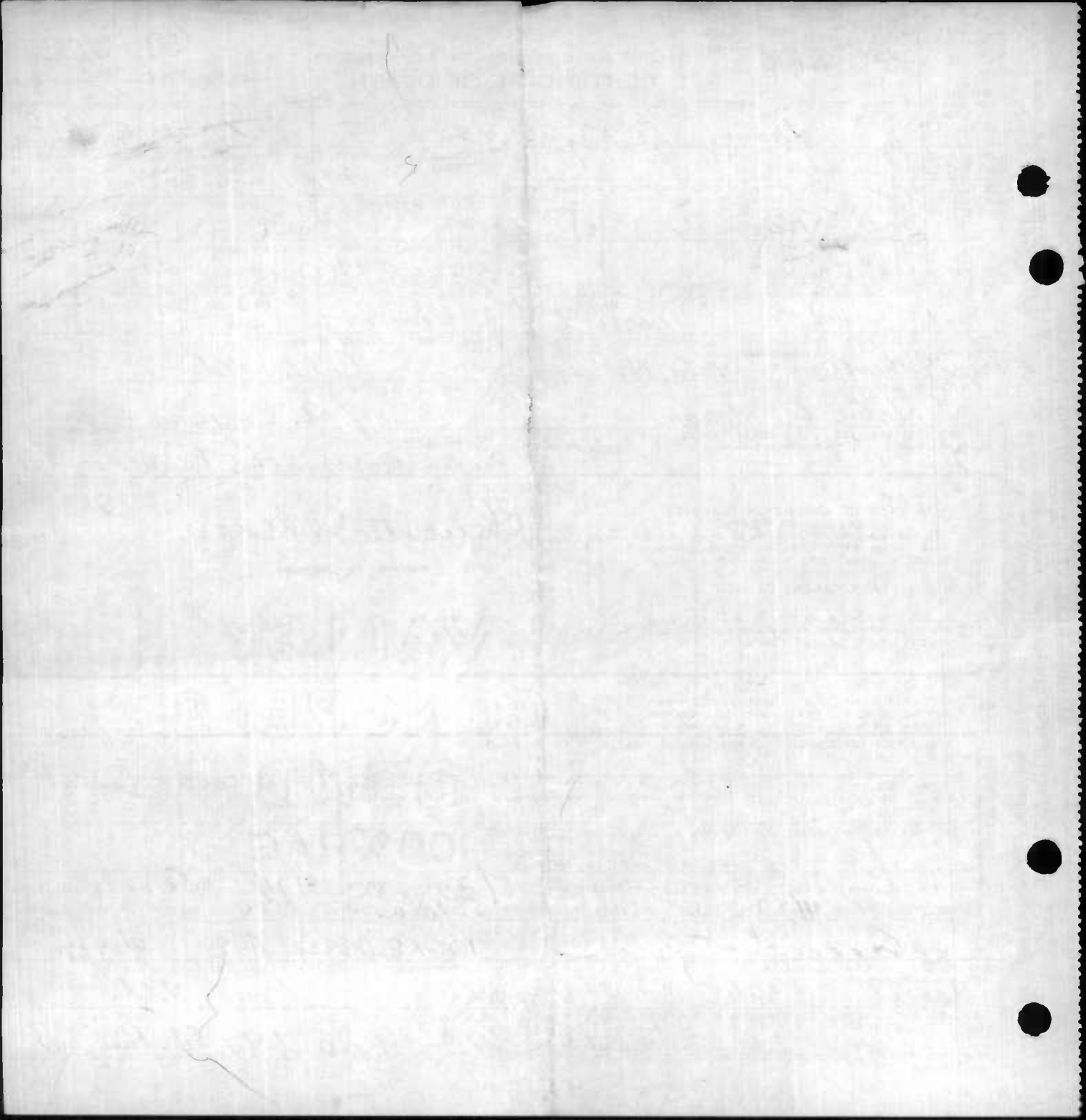
ADDRESS

Wm. Bok Inc 1217 St. Paul St

APR 25 1950

420 f6

93c





PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3799

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3799

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Thomas H. Thomas</b>		2. DATE OF DEATH <b>4/23/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>a. a. c.</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Balto. Gen'l Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>North Linthicum Heights</b>			
C. Length of stay in Baltimore <b>43</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>151 Heath Ave 5200</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6/26/1887</b>	9. AGE (In years last birthday) <b>62</b>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>First Aid</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Glidden Paint Co</b>		11. BIRTHPLACE (State or foreign country) <b>Nanticoke Pa</b>	
13. FATHER'S NAME <b>John Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-09-9965</b>		17. INFORMANT <b>Elizabeth Thomas Linthicum Heights</b>	
18. <b>260 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>DIABETES MELLITUS</b>		CAUSE OF DEATH (A) <b>DIABETES MELLITUS</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		(B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/22</b> , 1950, to <b>4/23</b> , 1950, that I last saw the deceased alive on <b>4/23</b> , 1950, and that death occurred at <b>7:40 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Samuel P. Scalia</b>		23B. ADDRESS <b>1213 Light Street</b>		23C. DATE SIGNED <b>4/23/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/26/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>	
24D. LOCATION (City, town, or county) (State) <b>Dorsey Md.</b>		25. FUNERAL DIRECTOR <b>William Williams, Inc.</b>		ADDRESS <b>1700 Park Ave. 217 St. Paul St.</b>	

THE UNIVERSITY OF CHICAGO

PLANTING STATION

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

CHICAGO, ILL.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully filled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3800

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3800

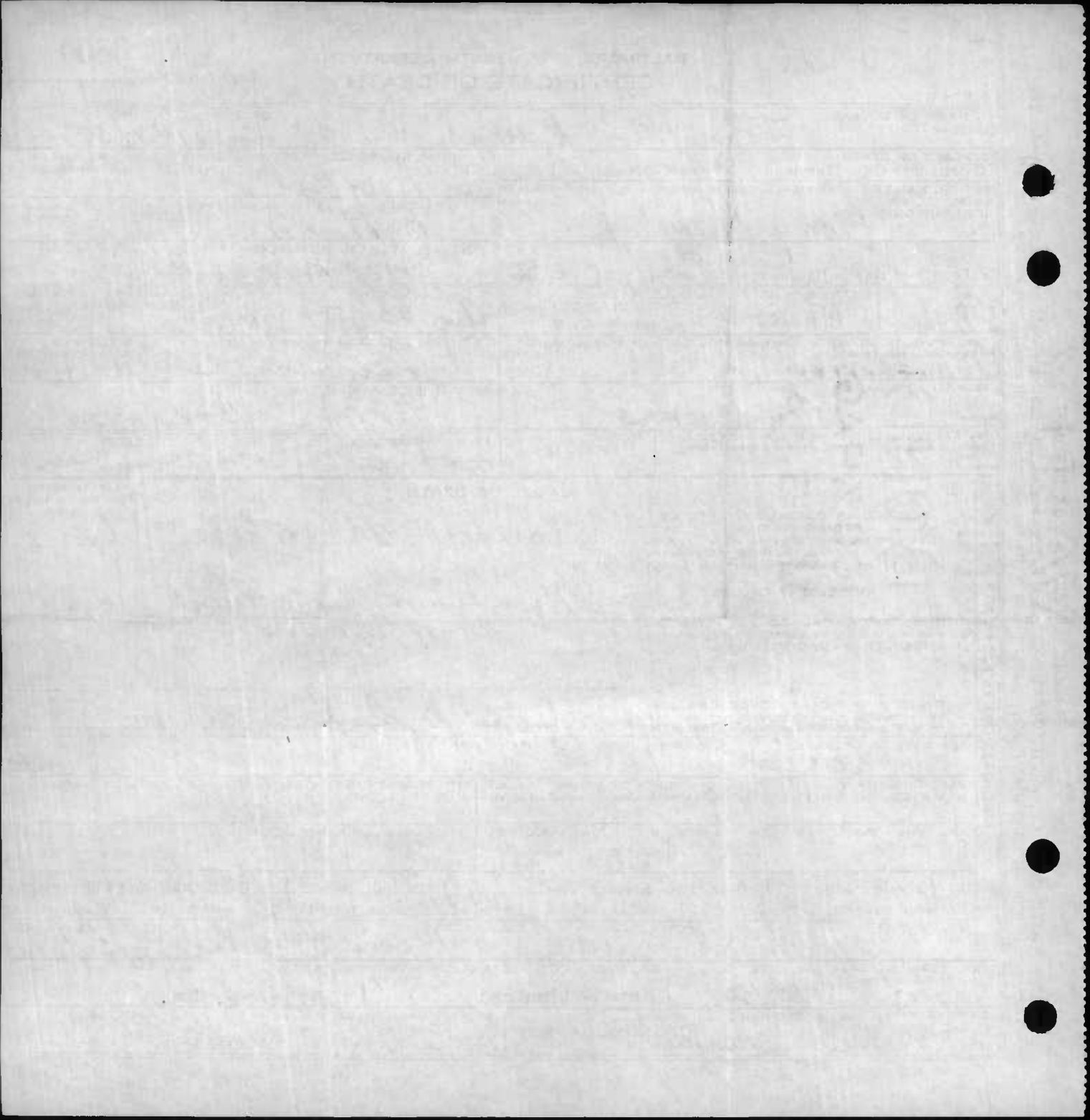
Registered No. \_\_\_\_\_

BIRTH NO. _____	
1. NAME OF DECEASED (Type or Print) <i>John M. Burns</i>	
2. DATE OF DEATH <i>4/24/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Md.</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Mercy Hospital</i>	
C. Length of stay in Baltimore <i>Twenty-five</i> Yrs. <i>25</i>	
5. SEX <i>Male</i>	6. COLOR, OR RACE <i>White</i>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug. 23, 1880</i>
9. AGE (In years last birthday) <i>69</i>	10. Under 1 Year Months: Days
11. Under 24 Hours Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Burns</i>	14. MOTHER'S MAIDEN NAME <i>Virginia Wrenne</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT <i>Mrs. Mary C. Burns</i> ADDRESS <i>2108 Erdman Ave.</i>	

MEDICAL CERTIFICATION

18. <i>442x</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Cerebral Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	CAUSE OF DEATH <i>Cerebral Hemorrhage</i>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <i>Hypertensive Cardio-Vascular Renal Disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 years+</i>	CAUSE OF DEATH <i>Hypertensive Cardio-Vascular Renal Disease</i>
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <i>Generalized Arteriosclerosis</i>	CAUSE OF DEATH <i>Generalized Arteriosclerosis</i>

19A. DATE OF OPERATION <i>None</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>18 April 1950</i> , to <i>24 April 1950</i> , that I last saw the deceased alive on <i>24 April 1950</i> , and that death occurred at <i>12:10 a.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Theresa S. Linn</i> M. D.	23B. ADDRESS <i>Mercy Hospital</i>	23C. DATE SIGNED <i>4/24/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4/26/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	25. FUNERAL DIRECTOR <i>W. W. Nepeus and Son</i> ADDRESS <i>805 W. Charles St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 25 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	



BE CAREFUL TO WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3801

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3801

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

SARAH SACHS

2. DATE  
OF  
DEATH

April 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

2623 Loyola Southway

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

15-13

D. STREET ADDRESS (If rural, give location)

2623 Loyola South ay

c. Length of stay in Baltimore

50 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

1870

9. AGE (In years last birthday)

80

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Lithunia

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME

Morris Sykes

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Edward J. Sachs-2623 Loyola Southway

18. 260X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Acute pulmonary edema

1 hour.

DUE TO

Hypertension

arteriosclerosis

ANTECEDENT CAUSES

(B)

Diabetes mellitus

12 years

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from August 1938, to April 24, 1950, that I last saw the deceased alive on April 24, 1950, and that death occurred at 2 A. M., from the causes and on the date stated above.

22A. SIGNATURE

22B. ADDRESS

22C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-25-50

24C. NAME OF CEMETERY OR CREMATORY

Enai Jacob Lodge

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

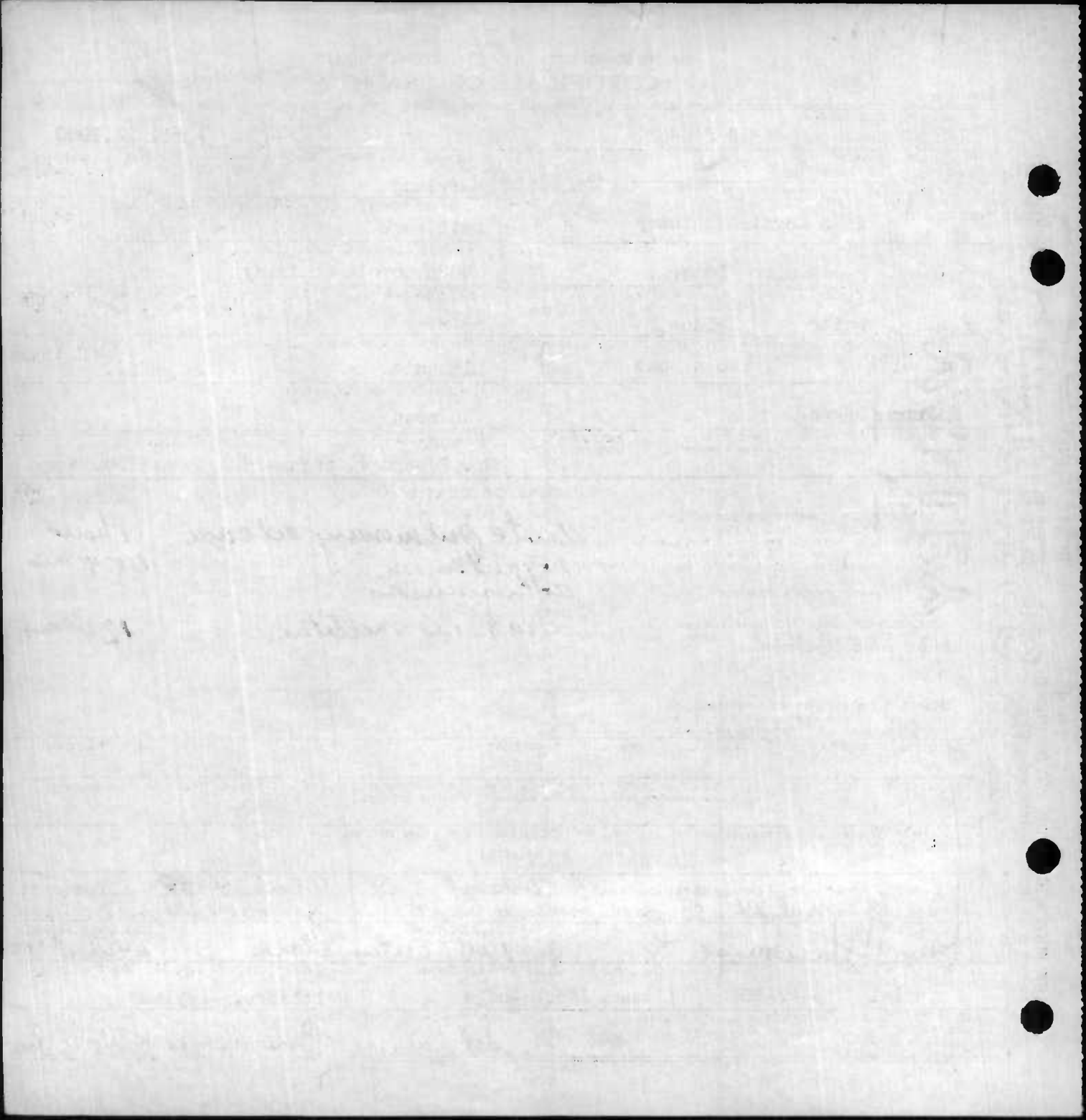
APR 25 1950

Huntington Williams, M.D.

Sol. Levinson &amp; Bros 1124-26 W. North Ave.

VS 150

61





K-320  
50 3802BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3802  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

NETTIE KATZ

2. DATE  
OF  
DEATH

April 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

719 W North Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

14-01

D. STREET ADDRESS (If rural, give location)

719 W North Avenue

c. Length of stay in Baltimore

45 Yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

1884

9. AGE (In years,  
last birthday)

66

If Under 1 Year  
Months; DaysIf Under 24 Hours  
Hours; Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Morris Glass

14. MOTHER'S MAIDEN NAME

Goldie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Fannie Kaplan-719 W North Avenue

18.

260X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Cormany Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

12 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Arteriosclerotic and Hypertensive

DUE TO

Cardio-vascular Disease

(C)

Diabetic Mellitus

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948 to 4-24, 1950 that I last saw the  
deceased alive on 4-24, 1950 and that death occurred at 1:50 a.m., from the causes and on the date stated above.

23A. SIGNATURE

D. D. Anderson

M. D.

23B. ADDRESS

1109 N. Calvert St

23C. DATE SIGNED

4-24-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-25-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Friendship

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

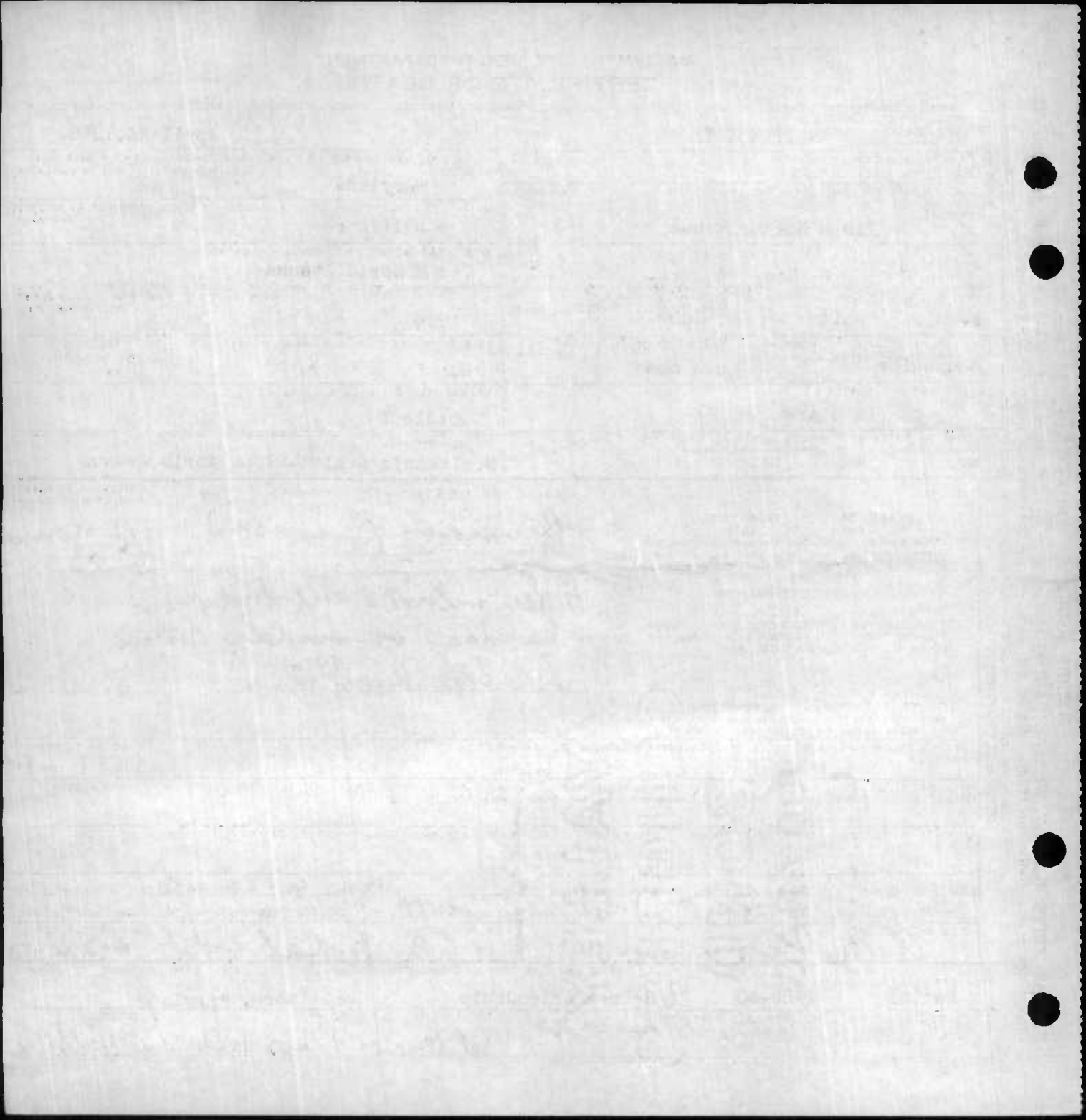
REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Sol Levine &amp; Bros 1124-26 W North Ave



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Melvin Charles Rose</u>			2. DATE OF DEATH <u>4/23/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore Md.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Catonsville 5300</u>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>1405 Ridge Road</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 6, 1900</u>	9. AGE (In years last birthday) <u>49 yrs.</u>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>C &amp; P Telephone Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frederick Rose</u>			14. MOTHER'S MAIDEN NAME <u>Helen Davis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Florence Beatrice Rosa - Same</u>		

18. 331X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 22, 1950, to April 23, 1950, that I last saw the deceased alive on April 23, 1950, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

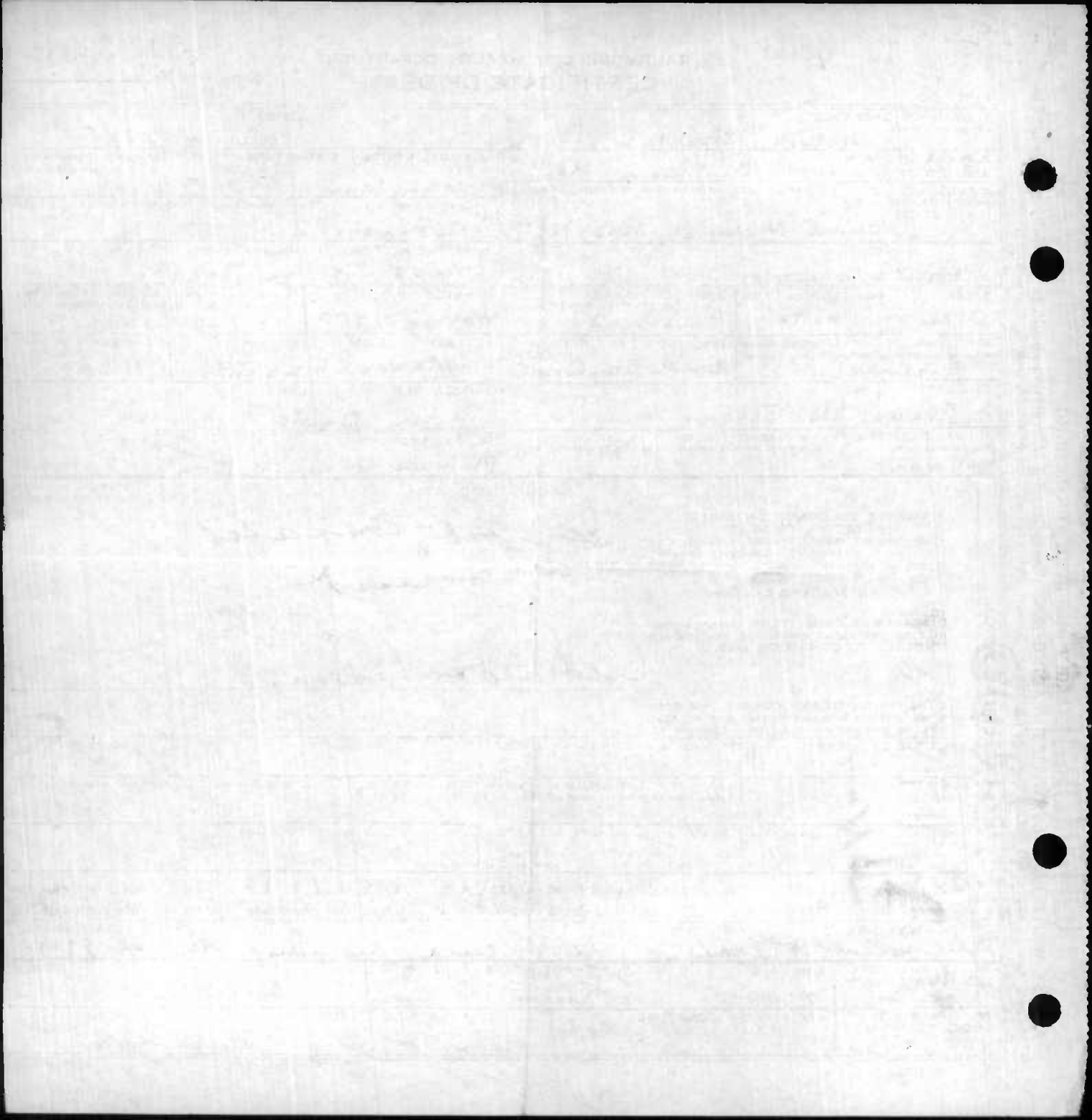
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3804

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>James Daniels</i>		2. DATE OF DEATH <i>4/24/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>South Baltimore General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 23-01</i>			
c. Length of stay in Baltimore <i>43</i> Yrs. Mos. Days		O. STREET ADDRESS (If rural, give location) <i>40 W. West street</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>43</i>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hardy Man</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>Matt Daniels</i>		14. MOTHER'S MAIDEN NAME <i>Fannie</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>022X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Rupture of aneurysm of abdominal aorta</i> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/22/50</i> , 19__, to <i>4/24/50</i> , 19__, that I last saw the deceased alive on <i>4/24/50</i> , 19__, and that death occurred at <i>4:40 A.</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>James A. Hayes</i>		23B. ADDRESS <i>1213 light street</i>		23C. DATE SIGNED <i>4/24/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-27-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wilson</i>	
24D. LOCATION (City, town, or county) (State) <i>n. c.</i>		25. FUNERAL DIRECTOR <i>James A. Hayes</i>		ADDRESS <i>638 N. 9th Street</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 25 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		FUNDING AGENCY <i>98859</i>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

DATE: 10/10/78

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. [REDACTED]

25. [REDACTED]

26. [REDACTED]

27. [REDACTED]

28. [REDACTED]

29. [REDACTED]

30. [REDACTED]

31. [REDACTED]

32. [REDACTED]

33. [REDACTED]

34. [REDACTED]

35. [REDACTED]

36. [REDACTED]

37. [REDACTED]

38. [REDACTED]

39. [REDACTED]

40. [REDACTED]



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 3805		BALTIMORE CITY HEALTH DEPARTMENT		50 3805	
BIRTH NO. 50-08500		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Barbara Jean LEWIS</b>		2. DATE OF DEATH <b>4-23-50</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION Memorial Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 14-01.</b>			
c. Length of stay in Baltimore <b>22 HRS</b>		D. STREET ADDRESS (If rural, give location) <b>1405 Mt. Royal Avenue</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>4-23-50</b>	9. AGE (In years last birthday) <b>4</b>	10. Under 1 Year Months: Days <b>22</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INFANT</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md</b>	
13. FATHER'S NAME <b>Born out of Wedlock</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET R. Lewis</b>	
17. INFORMANT <b>Edith L. Lewis, 1405 Mt. Royal Ave, City</b>		ADDRESS			
18. <b>763.0 I</b> CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH <b>22 HRS</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) ANOXIA</b>					
DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Aspiration Pneumonia</b>					<b>22 HRS</b>
DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C)</b>					
19A. DATE OF OPERATION <b>no</b>		19B. MAJOR FINDINGS OF OPERATION <b>no</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>no</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>no</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>no</b>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>no</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>no</b>			
22. I hereby certify that I attended the deceased from <b>4-23-1950</b> , to <b>4-23-1950</b> , that I last saw the deceased alive on <b>4-23-1950</b> , and that death occurred at <b>10:50 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Shellen F. Stengel</b>		23B. ADDRESS <b>Union Memorial Hospital</b>		23C. DATE SIGNED <b>4-23-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April-25-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 25 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>Stewart &amp; Mowen Co., 108 W. North Avenue City #1.</b>			



F-256

50 3806

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3806

Registered No.

4/23/50 April 23, 1950

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary C. Eisenhower

2. DATE  
OF  
DEATH

April 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4700 Hatford

4. USUAL RESIDENCE (Where deceased lived before admission)

A. STATE

Md

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

60 Hatford Convalescent Home

C. CITY OR TOWN

Balls 6-03

D. STREET ADDRESS (If rural, give location)

2322 Orleans St

C. Length of stay in Baltimore

life

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

July 2, 1873

9. AGE (in years,  
last birthday)

76

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Balls

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Enoch L. Porter

14. MOTHER'S MAIDEN NAME

Johannah Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Louis Eisenhower 1303 Luzerne Ave

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive C.V. disease

4 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

6 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Hemiplegia

4 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/26/45, 19\_\_, to 4/23/50, 19\_\_, that I last saw the  
deceased alive on 4/23, 19 50, and that death occurred at 11 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Becky B. Moore, M.D.

23B. ADDRESS

448 N. Luzerne Ave

23C. DATE SIGNED

4/24/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

April 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mount Carmel

24D. LOCATION (City, town, or county)

Balls

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

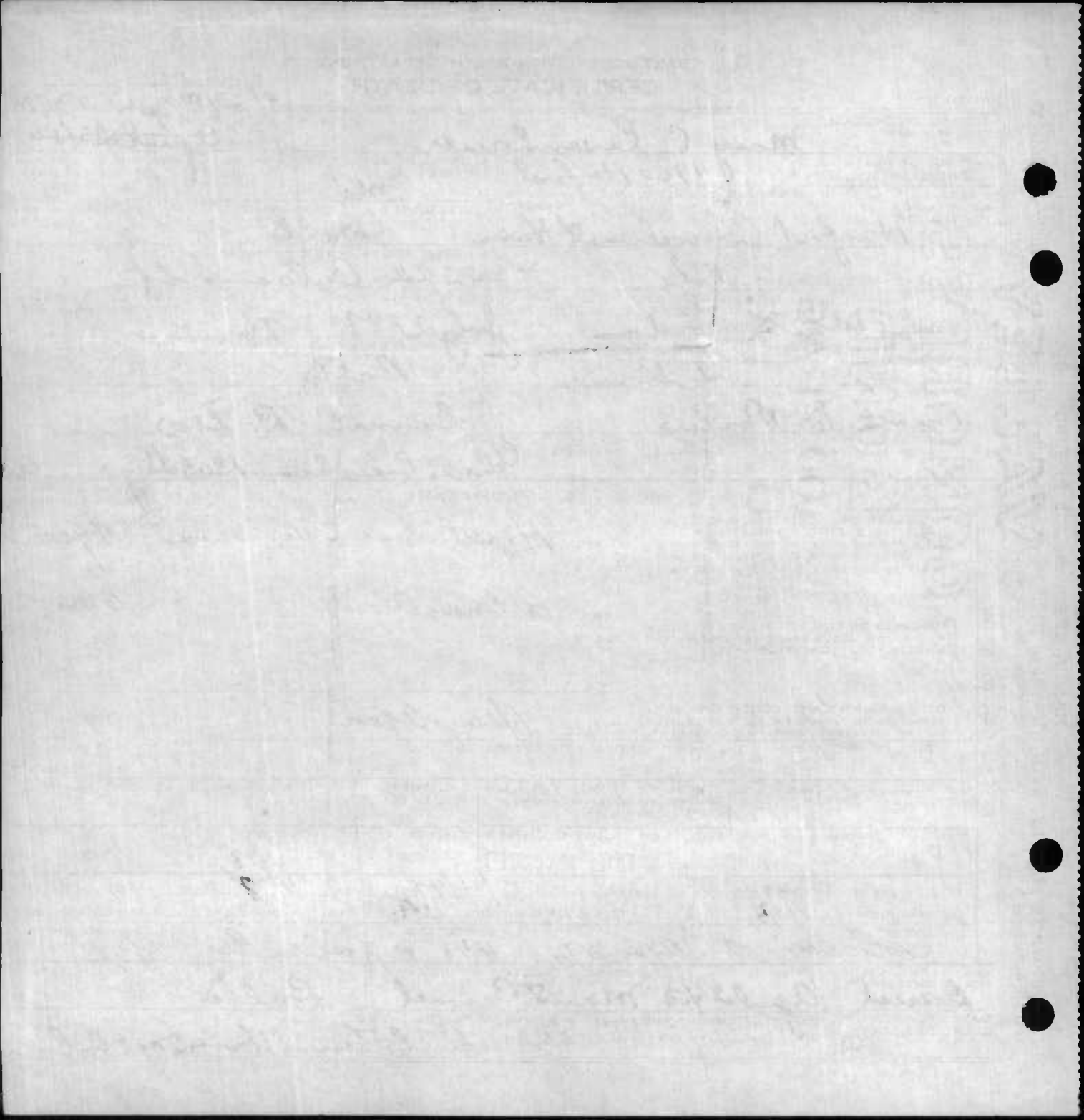
William L. Linnell Home 200 P &amp; L

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F. 640

50 3807

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3807

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bertha Fairley 144497

2. DATE  
OF  
DEATH APR 21 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 7-05

D. STREET ADDRESS (If rural, give location)

732 N Wolfe St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

female colored

M.

8A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

3-13-00 50

9. AGE (In years last birthday)

11 Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

N. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Nancy McNeil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Name and Address)

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 157 X I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinomatosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Post-operative shock

INTERVAL BETWEEN ONSET AND DEATH

2

19A. DATE OF OPERATION

Apr 21, 1950

19B. MAJOR FINDINGS OF OPERATION

Extensive Ca

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-4-1950 to 4-21-1950 that I last saw the deceased alive on 4-21-1950, and that death occurred at 11:22 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Edmund R. Hook

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

April 25/50

Mt Calvary Cem

GA County Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 25 1950

Huntington Williams, M.D.

Mrs. Robert G. Elbert &amp; Daughter



STATE OF NEW YORK  
DEPARTMENT OF HEALTH

Death Certificate

No.

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

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100-100000

100-100000

100-100000



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

13-300  
50 3808

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3808

Registered No. \_\_\_\_\_

BIRTH NO. _____			
1. NAME OF DECEASED (Type or Print) <i>Frank</i>		2. DATE OF DEATH <i>4-23-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 7-05</i>	
c. Length of stay in Baltimore <i>1918</i>		D. STREET ADDRESS (If rural, give location) <i>707 N. Dallas St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>July 23, 1915</i>
9. AGE (In years last birthday) <i>35</i>		10. Under 1 Year: Months _____ Days _____ 11. Under 24 Hours: Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed Labourer</i>		10B. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <i>Bay Cross, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>Frank Bethea</i>		14. MOTHER'S MAIDEN NAME <i>Edna Lipp</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Frank Bethea</i>		ADDRESS <i>707 N. Dallas</i>	

18.	155 X I		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Carcinomatosis, generalized</i>	
	DUE TO		(B) <i>Anaplastic carcinoma of liver</i>	
	DUE TO		(C) <i>over</i>	
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION <i>none</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact locations) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <i>4/21</i> , 1950, to <i>4/23</i> , 1950, that I last saw the deceased alive on <i>4/23</i> , 1950, and that death occurred at <i>12:55 P.M.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>James M. Bisanar</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>4/23/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	24B. DATE <i>April 26, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cms &amp; A County Md</i>		24D. LOCATION (City, town, or county) (State) <i>11297 N. Carroll St 46F</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 25 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Rev Robert A. Elliott &amp; Daugh</i>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Handwritten notes and signatures, including "Frank D. ...", "J. Edgar Hoover", and "Special Agent in Charge".

Letter in document file 50-3808- 5/9/50.

Handwritten notes at the bottom of the page, including "The Bureau of Investigation" and "U.S. Department of Justice".

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH442X  
50 3809  
Registered No. 50-3809

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ella Taylor

2. DATE  
OF  
DEATH April 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

70 N. M. Carroll Aged Home

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)

Baltimore

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

822 N. Carrollton Ave.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years last birthday) 76  
If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Dennis

14. MOTHER'S MAIDEN NAME

Hester Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Samuel Moore-804 Harlem Ave.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHI  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) Arteriosclerotic cardio-renal  
disease

1 yr.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis

?

DUE TO

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. - , 1950, to Jan. - , 1950, that I last saw the deceased alive on Jan. - , 1950, and that death occurred at 9 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas W. Harris

M. D.

23B. ADDRESS

1824 W. Franklin St.

23C. DATE SIGNED

4-23-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-26-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 25 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Frances A. Hemsley-578 W. Biddle St.

(over)

131a

M. H. Carroll aged 16 yrs

No former address known

J.P.B.

1895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-610

50 3810

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3810  
Registered No.

BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <b>EDWARD GRIPP</b>			2. DATE OF DEATH <b>APRIL 24, 1950</b>
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md</i>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 19-04</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1702 FREDERICK AVE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JULY 23 1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER LAYER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	9. AGE (In years last birthday) <b>54</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Charles Gripp</b>		14. MOTHER'S MAIDEN NAME <b>ANNA TURAU</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>218-01-8079</b>	17. INFORMANT ADDRESS <b>WIFE, ANNA GRIPP. SAME</b>
18. <b>490X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>LOBAR PNEUMONIA.</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>CONGESTIVE HEART FAILURE.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS.</b>
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>APRIL 16</b> , 19 <b>50</b> to <b>24 APRIL</b> , 19 <b>50</b> that I last saw the deceased alive on <b>24 APRIL</b> , 19 <b>50</b> , and that death occurred at <b>9:05 AM.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <i>John W. Tugel</i>		23B. ADDRESS <b>FRANKLIN SQUARE HOSPITAL.</b>	23C. DATE SIGNED <b>24 April 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>apr 27. 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Western</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 25 1950</b>		REGISTRAR'S SIGNATURE <i>Huntington Williams, MD</i>	
25. FUNERAL DIRECTOR <b>306 V9</b>		ADDRESS <b>Mr. Mrs. John W. Tugel - 5311 Edmondson Ave</b>	



VALLEY  
COLUMBIA  
COLUMBIA  
COLUMBIA



M-622

50 3811

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3811

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Pelagia Tillie Mierkiewicz

2. DATE  
OF  
DEATH

4/22/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. City

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

708 S. Bethel St

4. USUAL RESIDENCE (Where deceased lived, If institution; residence  
before admission)

A. STATE

Md.

B. COUNTY

2-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Balto. City

D. STREET ADDRESS (If rural, give location)

708 S. Bethel St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1876

9. AGE (In years,  
last birthday)

74

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. C.

13. FATHER'S NAME

Jan Kluczynski

14. MOTHER'S MAIDEN NAME

✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Pearl Radtke 13358 Clinton St

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

arterio Sclerotic heart  
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

general arterio Sclerosis  
chronic hepatitis 2 yr.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/4 1949 to 4-22, 1950, that I last saw the  
deceased alive on 4-20, 1950, and that death occurred at 9:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

H. Q. Michelson

M. D.

23B. ADDRESS

2230 Eastern Pl.

23C. DATE SIGNED

4/23/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus

24D. LOCATION (City, town, or county)

Balto. City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

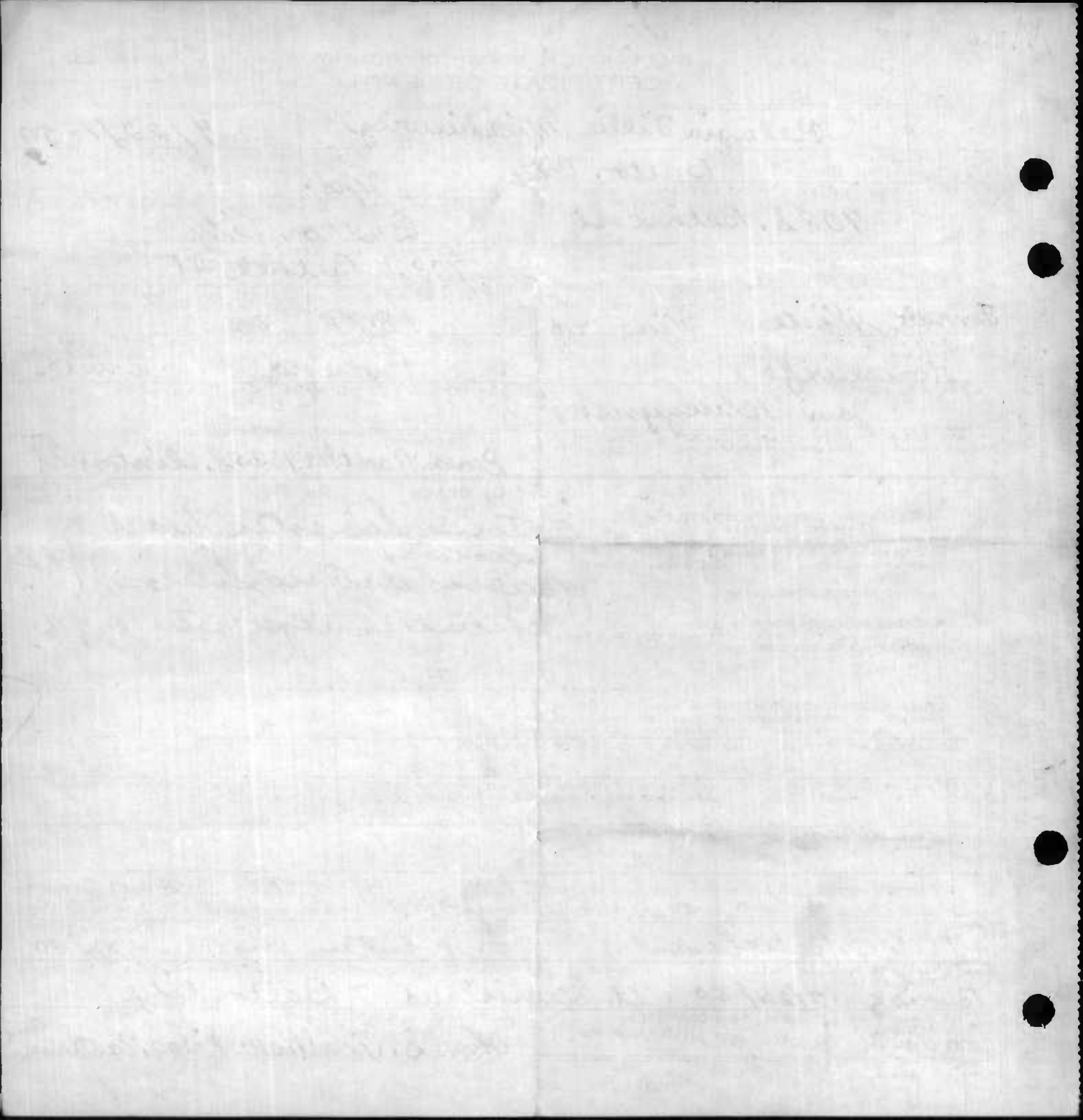
Wm. S. Fialkowski 2007 Eastern Ave

VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



H-516

50 3812

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3812

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

AMELIA HAMBURGER

2. DATE  
OF  
DEATH

April 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balt City

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

4515 Garrison Blvd

C. CITY OR TOWN (If inside corporate limits, write RURAL and give township)

Baltimore Md 15-10

C. Length of stay in Baltimore

60 years

D. STREET ADDRESS (If rural, give location)

4017 Spungdale ave

5. SEX

6. COLOR OR RACE

SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Stanley H. Hamburger 4017 Spungdale ave

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Insufficiency of age

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

Arteriosclerotic Cordis

(C) DUE TO

Vase Renal Disease

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office hldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 3-24, 1949 to 4-24, 1950 that I last saw the  
deceased alive on 4-23, 1950, and that death occurred at 9 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 25 1950

Huntington Williams, M.D.

Daniel Sordheim, Jr. 1902 Easton place

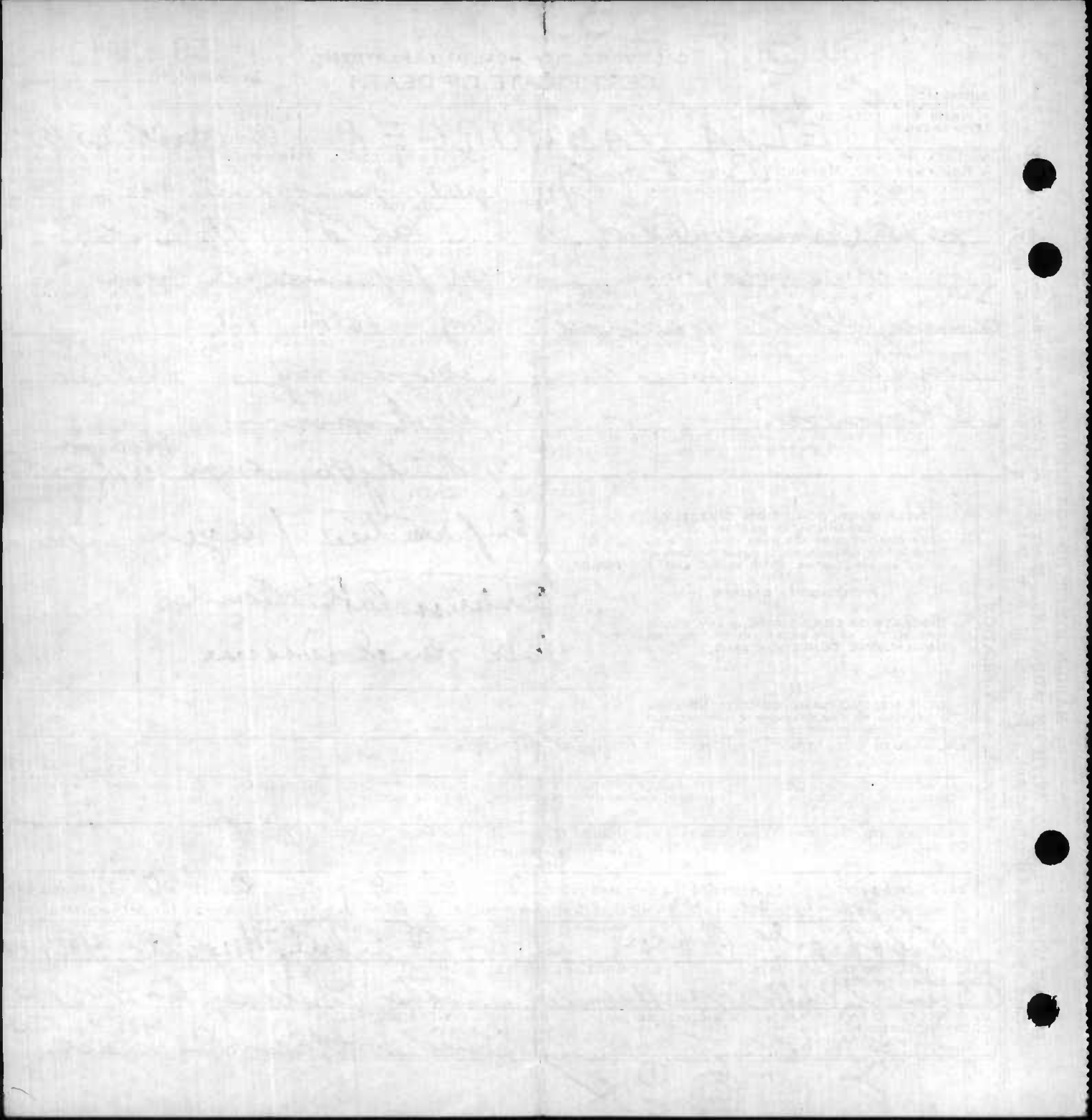
VS 150

131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Jan 1, 1950, to April 23, 1950, that I last saw the deceased alive on April 21, 1950, and that death occurred at 11:20 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 25 1950

VS 150

326 37

95c



Please state what was,  
in your opinion -  
the underlying cause of death.

Letter in document file 50-3813 - 5/4/50.



MS--137233

50

3814

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50

3814

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Queen

2. DATE  
OF  
DEATH

4-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1639 Booker Ct. Zone 17

c. Length of stay in Baltimore

60 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 12, 1866

9. AGE (In years  
last birthday)

84

H Under 1 Year  
Months: DaysH Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of worklog life, even if retired)

HARDCARRIER

10B. KIND OF BUSINESS OR  
INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

?

14. MOTHER'S MAIDEN NAME

?

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Baltimore City Hospitals  
Records\* 4940 Eastern Ave.

18.

610X

I

153X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

(B) Nephrosclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C) Prostatic Hypertrophy

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Probable Carcinoma of large bowel

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 4-11-1950, to 4-20-1950, that I last saw the  
deceased alive on 4-20-1950, and that death occurred at 12:15 Pm., from the causes and on the date stated above.

23A. SIGNATURE

J. Rogers

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

BURIAL

4-25-50

MT. AUBURN

BALTIMORE 30. MO.

APR 25 1950

Huntington Williams, M.D.

Wm. A. JACKSON-916 PENNA. AVE.

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 3815**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**RACHEL KEVIN**

2. DATE  
OF  
DEATH

**4-24-50**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

**Md**

B. FULL NAME OF (If not in hospital or institution, give street address or location)

**4025 Loorman Ave**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore 27-17**

c. Length of stay in Baltimore

**40**

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

**3004 W Garrison Ave**

5. SEX

**Female**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**married**

8. DATE OF BIRTH

9. AGE (in years, birth day)

**70**

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Russia**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Not known**

14. MOTHER'S MAIDEN NAME

**Not known**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Isaac Levin 3004 W Garrison Ave**

18. **420.1**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

**Coronary Occlusion**

INTERVAL BETWEEN ONSET AND DEATH

**2 days**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

**Hypertensive Cardiac Vascular Disease**

**unknown**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

19A. DATE OF OPERATION

**none**

19B. MAJOR FINDINGS OF OPERATION

**none**

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 24, 1950**, to **April 24, 1950**, that I last saw the deceased alive on **April 24, 1950**, and that death occurred at **5 P. M.**, from the causes and on the date stated above.

23A. SIGNATURE

**William E. Loorman**

M. O.

23B. ADDRESS

**4843 Park Heights Ave**

23C. DATE SIGNED

**4-25-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**4-25-50**

24C. NAME OF CEMETERY OR CREMATORY

**Rosedale**

24D. LOCATION (City, town, or county)

**Balto**

(State)

**Md**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**William E. Loorman**

25. FUNERAL DIRECTOR

**Isaac Levin 2100 Eutaw Pl**

ADDRESS

**2100 Eutaw Pl**

VS 150

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Lowman  
3005 W Garrison Ave  
Park Heights to right  
9711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 3816

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Marcellena Johns*2. DATE  
OF DEATH*April 23, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Maryland*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*1602 Etting St.*

C. CITY OR TOWN

*Baltimore 14-02*

D. STREET ADDRESS (If rural, give location)

*1602 Etting St.*

c. Length of stay in Baltimore

*Life*

5. SEX

*Female*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*Feb. 3, 1895*

9. AGE (In years last birthday)

*55*

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10B. KIND OF BUSINESS OR INDUSTRY

*Home*

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Leaw Wright*

14. MOTHER'S MAIDEN NAME

*Joy L. Carter*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

*E. Victor Wright Drivest Hill Ave*

ADDRESS

*1602 Etting St.*

18.

*175X*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

*(A) Carcinomatosis (Ovarian origin)*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*Unknown*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3-20*, 1950, to *4-23*, 1950, that I last saw the deceased alive on *4-21*, 1950, and that death occurred at *6:30* a.m., from the causes and on the date stated above.

23A. SIGNATURE

*Dr. Campbell*

23B. ADDRESS

*718 Dolphin St.*

23C. DATE SIGNED

*4-24-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*April 26, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Arthurs Mem. Park*

24D. LOCATION (City, town, or county)

*Bald, Co. Ind.*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

*APR 25 1950*

REGISTRAR'S SIGNATURE

*John J. Williams, M.D.*

25. FUNERAL DIRECTOR

*Holland Funeral Home*

ADDRESS

*1602 Etting St.*



STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of military		26. Signature of religious		27. Signature of social		28. Signature of cultural	
29. Signature of sports		30. Signature of entertainment		31. Signature of education		32. Signature of health	
33. Signature of science		34. Signature of technology		35. Signature of industry		36. Signature of commerce	
37. Signature of finance		38. Signature of law		39. Signature of justice		40. Signature of peace	
41. Signature of order		42. Signature of harmony		43. Signature of unity		44. Signature of love	
45. Signature of hope		46. Signature of faith		47. Signature of charity		48. Signature of kindness	
49. Signature of gentleness		50. Signature of patience		51. Signature of self-control		52. Signature of perseverance	
53. Signature of courage		54. Signature of strength		55. Signature of endurance		56. Signature of resilience	
57. Signature of determination		58. Signature of commitment		59. Signature of dedication		60. Signature of devotion	
61. Signature of loyalty		62. Signature of integrity		63. Signature of honesty		64. Signature of truthfulness	
65. Signature of sincerity		66. Signature of openness		67. Signature of transparency		68. Signature of accountability	
69. Signature of responsibility		70. Signature of leadership		71. Signature of influence		72. Signature of inspiration	
73. Signature of motivation		74. Signature of passion		75. Signature of enthusiasm		76. Signature of energy	
77. Signature of focus		78. Signature of determination		79. Signature of persistence		80. Signature of perseverance	
81. Signature of endurance		82. Signature of resilience		83. Signature of determination		84. Signature of commitment	
85. Signature of dedication		86. Signature of devotion		87. Signature of loyalty		88. Signature of integrity	
89. Signature of honesty		90. Signature of truthfulness		91. Signature of sincerity		92. Signature of openness	
93. Signature of transparency		94. Signature of accountability		95. Signature of responsibility		96. Signature of leadership	
97. Signature of influence		98. Signature of inspiration		99. Signature of motivation		100. Signature of passion	
101. Signature of enthusiasm		102. Signature of energy		103. Signature of focus		104. Signature of determination	
105. Signature of persistence		106. Signature of perseverance		107. Signature of endurance		108. Signature of resilience	
109. Signature of determination		110. Signature of commitment		111. Signature of dedication		112. Signature of devotion	
113. Signature of loyalty		114. Signature of integrity		115. Signature of honesty		116. Signature of truthfulness	
117. Signature of sincerity		118. Signature of openness		119. Signature of transparency		120. Signature of accountability	
121. Signature of responsibility		122. Signature of leadership		123. Signature of influence		124. Signature of inspiration	
125. Signature of motivation		126. Signature of passion		127. Signature of enthusiasm		128. Signature of energy	
129. Signature of focus		130. Signature of determination		131. Signature of persistence		132. Signature of perseverance	
133. Signature of endurance		134. Signature of resilience		135. Signature of determination		136. Signature of commitment	
137. Signature of dedication		138. Signature of devotion		139. Signature of loyalty		140. Signature of integrity	
141. Signature of honesty		142. Signature of truthfulness		143. Signature of sincerity		144. Signature of openness	
145. Signature of transparency		146. Signature of accountability		147. Signature of responsibility		148. Signature of leadership	
149. Signature of influence		150. Signature of inspiration		151. Signature of motivation		152. Signature of passion	
153. Signature of enthusiasm		154. Signature of energy		155. Signature of focus		156. Signature of determination	
157. Signature of persistence		158. Signature of perseverance		159. Signature of endurance		160. Signature of resilience	
161. Signature of determination		162. Signature of commitment		163. Signature of dedication		164. Signature of devotion	
165. Signature of loyalty		166. Signature of integrity		167. Signature of honesty		168. Signature of truthfulness	
169. Signature of sincerity		170. Signature of openness		171. Signature of transparency		172. Signature of accountability	
173. Signature of responsibility		174. Signature of leadership		175. Signature of influence		176. Signature of inspiration	
177. Signature of motivation		178. Signature of passion		179. Signature of enthusiasm		180. Signature of energy	
181. Signature of focus		182. Signature of determination		183. Signature of persistence		184. Signature of perseverance	
185. Signature of endurance		186. Signature of resilience		187. Signature of determination		188. Signature of commitment	
189. Signature of dedication		190. Signature of devotion		191. Signature of loyalty		192. Signature of integrity	
193. Signature of honesty		194. Signature of truthfulness		195. Signature of sincerity		196. Signature of openness	
197. Signature of transparency		198. Signature of accountability		199. Signature of responsibility		200. Signature of leadership	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3817**

BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Clarence A. Euler		April 24 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
4006 Ridgewood Ave		A. STATE Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
00		Baltimore 15-10	
c. Length of stay in Baltimore		O. STREET ADDRESS (If rural, give location)	
Life Yrs. Mos. Days		4006 Ridgewood Ave	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Male	White	Married	Dec 14 1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Chg Safe Deposit		Md. Trust Co	75
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Baltimore Md			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jacob Euler		Augusta Oehne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or oookown) (If yes, give war or dates of service)		17. INFORMANT ADDRESS	
		Anna Euler 4006 Ridgewood Ave	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
(A)		Coronary Thrombosis	
ANTECEDENT CAUSES		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Arterio-sclerotic heart disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) Partial hemiplegia	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April, 1945 to April 24, 1950, that I last saw the deceased alive on April 21, 1950, and that death occurred at 8 P. M., from the causes and on the date stated above.			
23A. SIGNATURE		23B. ADDRESS	
George S. H. [Signature]		5106 Park Heights Ave	
M. O.		23C. DATE SIGNED	
		4/24/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	Apr 27 1950	Loudon Park	Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR ADDRESS	
APR 25 1950	Huntington Williams, M.D.	Harry J. [Signature] 4204 Ridgewood Ave	

CERTIFICATE OF DEATH

STATE OF NEW YORK

COUNTY OF ...

CITY OF ...

DECEASED ...

DATE OF DEATH ...

PLACE OF DEATH ...

CAUSE OF DEATH ...

SIGNATURE OF ...

DATE ...

PLACE ...

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-16/30 3818

WOTHBRAB  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3818  
Registered No.

BIRTH NO.				2. DATE OF DEATH 4-24-50			
1. NAME OF DECEASED (Type or Print) <i>Esther Mary Annulpha Wothbrab</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
3. PLACE OF DEATH: A. Baltimore City, Maryland				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 10-02</i>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>St. Joseph's Hospital</i>				D. STREET ADDRESS (If rural, give location) <i>901 Aisquith Street</i>			
c. Length of stay in Baltimore 41 Yrs. Mos. Days							
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>June 5, 1876</i>		9. AGE (In years last birthday) <i>73 7 10 16</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Religious</i>		BIRTHPLACE (State or foreign country) <i>Rochester N.Y.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Alois Wothbrab</i>				14. MOTHER'S MAIDEN NAME <i>Clara Fiechholz</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>S. M. Stow, Nurse</i>		ADDRESS	
18. <i>5705</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Coronary heart failure</i> DUE TO (B) <i>Intestinal obstruction</i> DUE TO (C) <i>Pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH				19. DATE OF OPERATION <i>0</i>			
19A. DATE OF OPERATION <i>0</i>				19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4/23/50</i> , to <i>4/24/50</i> , that I last saw the deceased alive on <i>4/24/50</i> , and that death occurred at <i>3:25 P.m.</i> from the causes and on the date stated above.							
23A. SIGNATURE <i>William B. Rogers M.D.</i>		23B. ADDRESS <i>St. Joseph's Hospital</i>		23C. DATE SIGNED <i>4/24/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Apr 26/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>North Cliff</i>		24D. LOCATION (City, town, or county) (State) <i>Green Arm</i>	
DATE RECEIVED BY APOL REGISTRAR <i>APR 25 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, MD</i>		25. FUNERAL DIRECTOR <i>Geo M. Farris &amp; Son</i>		ADDRESS	

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-650  
50 3819

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 3819

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		HELEN BROWN		April 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 253 W. Hoffman Street			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 3, 1889	9. AGE (In years last birthday) 61	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Jackson		14. MOTHER'S MAIDEN NAME Gussie		17. INFORMANT Eugene Thomas-W. Mosher St.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		ADDRESS 1945	

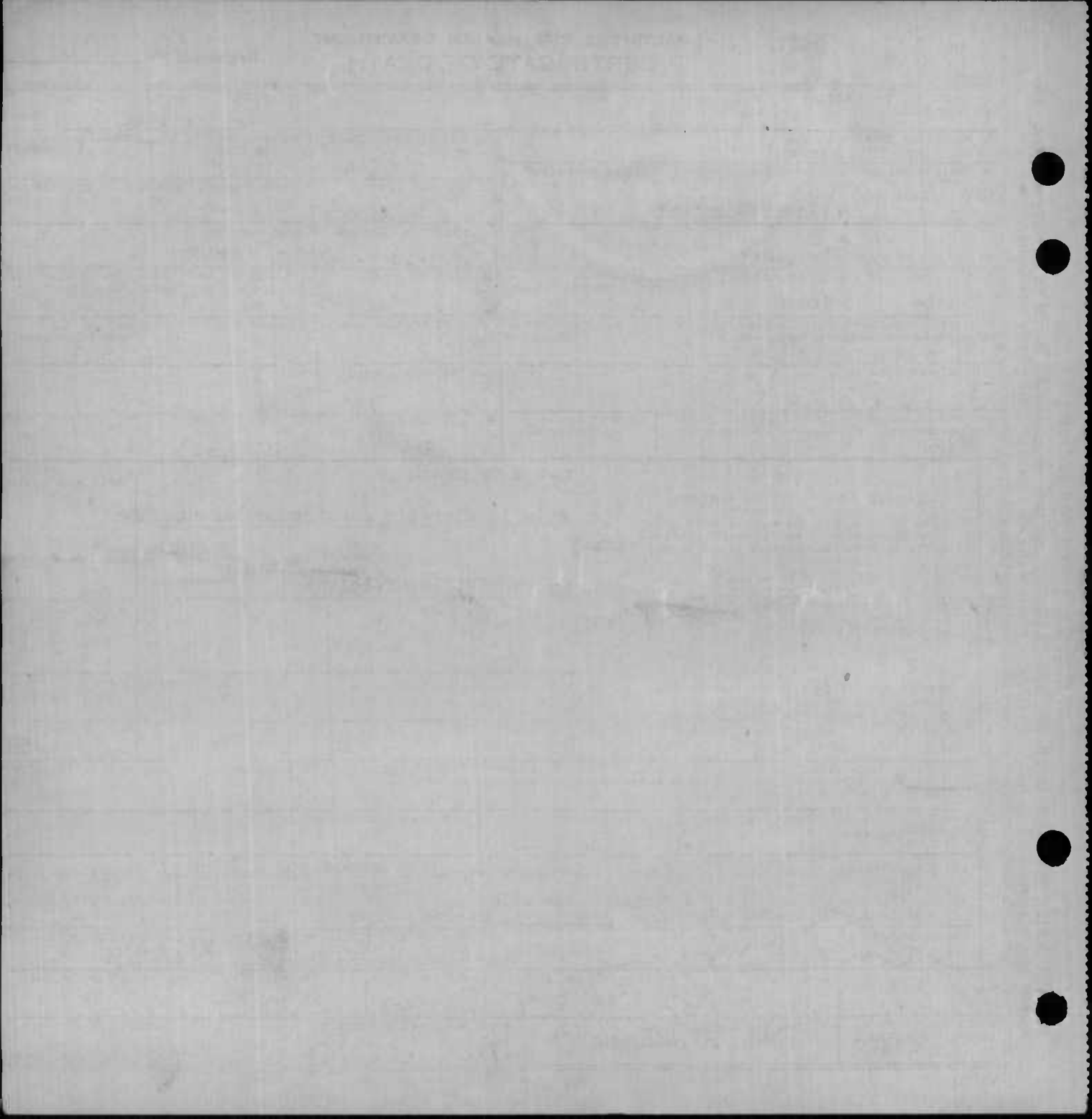
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Myocardial insufficiency			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE E. L. Royer	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED 4/22/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-25-1950	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem
24D. LOCATION (City, town, or county) Balto.	24E. STATE Md.	25. FUNERAL DIRECTOR Thos. Hater R. Williams
DATE RECEIVED BY LOCAL REGISTRAR APR 25 1950		ADDRESS 322 N. Schroeder St.

77087

93D ✓





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary A. Curry

2. DATE  
OF  
DEATH

4-22-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Provident Hosp.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

16-01

d. STREET ADDRESS (If rural, give location)

819 N. Arlington Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 2, 1899

9. AGE (In years  
last birthday)

50

If Under 1 Year  
Months: Days: Hours: Min.

11. BIRTHPLACE (State or foreign country)

Howard Co. Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Cook

10b. KIND OF BUSINESS OR  
INDUSTRY

Domestic

13. FATHER'S NAME

Benjamin Curry

14. MOTHER'S MAIDEN NAME

Henrietta Snell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.7. INFORMANT ADDRESS  
Ada Breen Harlem 934

18. 260 X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Diabetic acidosis

more than  
5 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Diabetes mellitus

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, to 4-22, 1950, that I last saw the  
deceased alive on 4-22, 1950, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE

Charles T. Woodley

23b. ADDRESS

819 N. Arlington Ave

23c. DATE SIGNED

4-22-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24b. DATE

4-26-1950

24c. NAME OF CEMETERY OR CREMATORY

Colesville

24d. LOCATION (City, town, or county)

Colesville Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

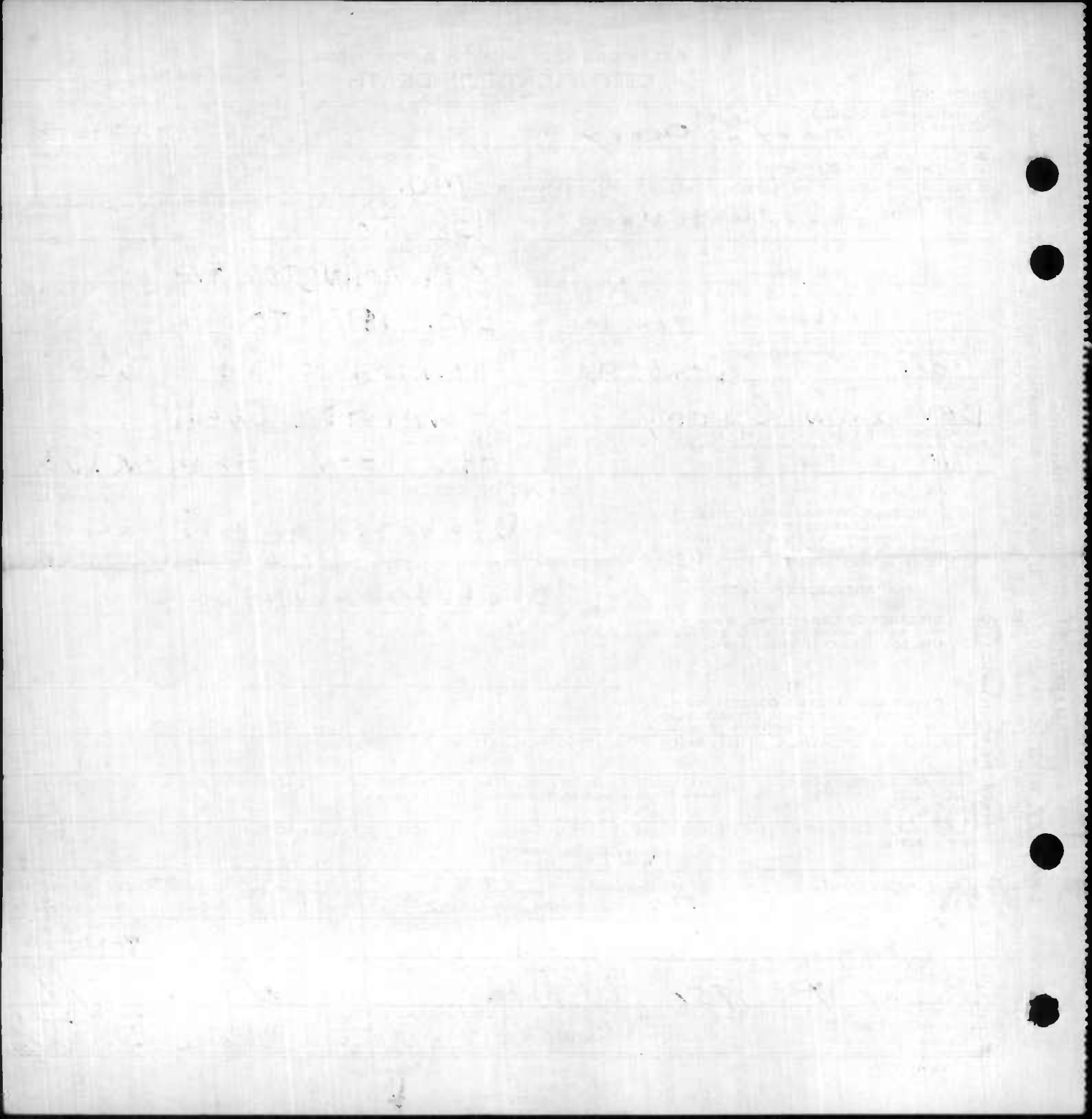
REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Mrs. Kate R. Williams Schroeder

ADDRESS 3227



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3821  
Registered No. \_\_\_\_\_

BIRTH NO. 3821 59-11060

1. NAME OF DECEASED (Type or Print) <b>Verna Mae McDermott</b>		2. DATE OF DEATH <b>April 25, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>125 S. Schroeder St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 18-03</b>	
D. STREET ADDRESS (If rural, give location) <b>125 S. Schroeder St.</b>		Yrs. Mos. Days	
c. Length of stay in Baltimore <b>Life</b>			
5. SEX <b>White</b>	6. COLOR OR RACE <b>Female</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>5/16/1949</b>
9. AGE (In years last birthday) <b>11</b>		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Ind.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl M. M. McDermott</b>		14. MOTHER'S MAIDEN NAME <b>Mary L. Shannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Earl M. M. McDermott</b>		ADDRESS <b>125 S. Schroeder St.</b>	

18. <b>391.2</b>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <b>Septicemia due to acute purulent otitis media, right ear</b>	<b>2 das.</b>
ANTECEDENT CAUSES		(B) _____	_____
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.		(C) _____	_____
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		_____	_____

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>R. B. Fisher</b>	23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	23C. DATE SIGNED <b>April 25, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/27/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Gen</b>
24D. LOCATION (City, town, or county) <b>4300 Old Frederick Rd.</b>	(State) _____	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 25 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>John J. C. Swan &amp; Son</b>
ADDRESS <b>89a St.</b>		

CERTIFICATE OF DEATH

State of New York

County of \_\_\_\_\_

City of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3822  
Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DR. HUGH FORSYTHE.

2. DATE  
OF  
DEATH

24 APR. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION 352 ROSEBANK AVE.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE. 27-12

D. STREET ADDRESS (If rural, give location)

352 E. ROSEBANK AVE.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

MALE.

6. COLOR OR RACE

WHITE.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12 Jan. 1866.

9. AGE (In years, last birthday)

84

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PHYSICIAN.

10B. KIND OF BUSINESS OR INDUSTRY

Medical

11. BIRTHPLACE (State or foreign country)

Ireland.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Forsythe.

14. MOTHER'S MAIDEN NAME

Blakeley.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Daughter.

ADDRESS

352 Rosebank Ave

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, terminal 21 Apr '50.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular disease

(C) Senility.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 March, 1950, to 24th APR, 1950, that I last saw the deceased alive on 24 Apr., 1950, and that death occurred at 9:25 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Joseph E. Muse Jr. M.D.

23B. ADDRESS

5 West 29th St.

23C. DATE SIGNED

24 Apr. 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 25 1950

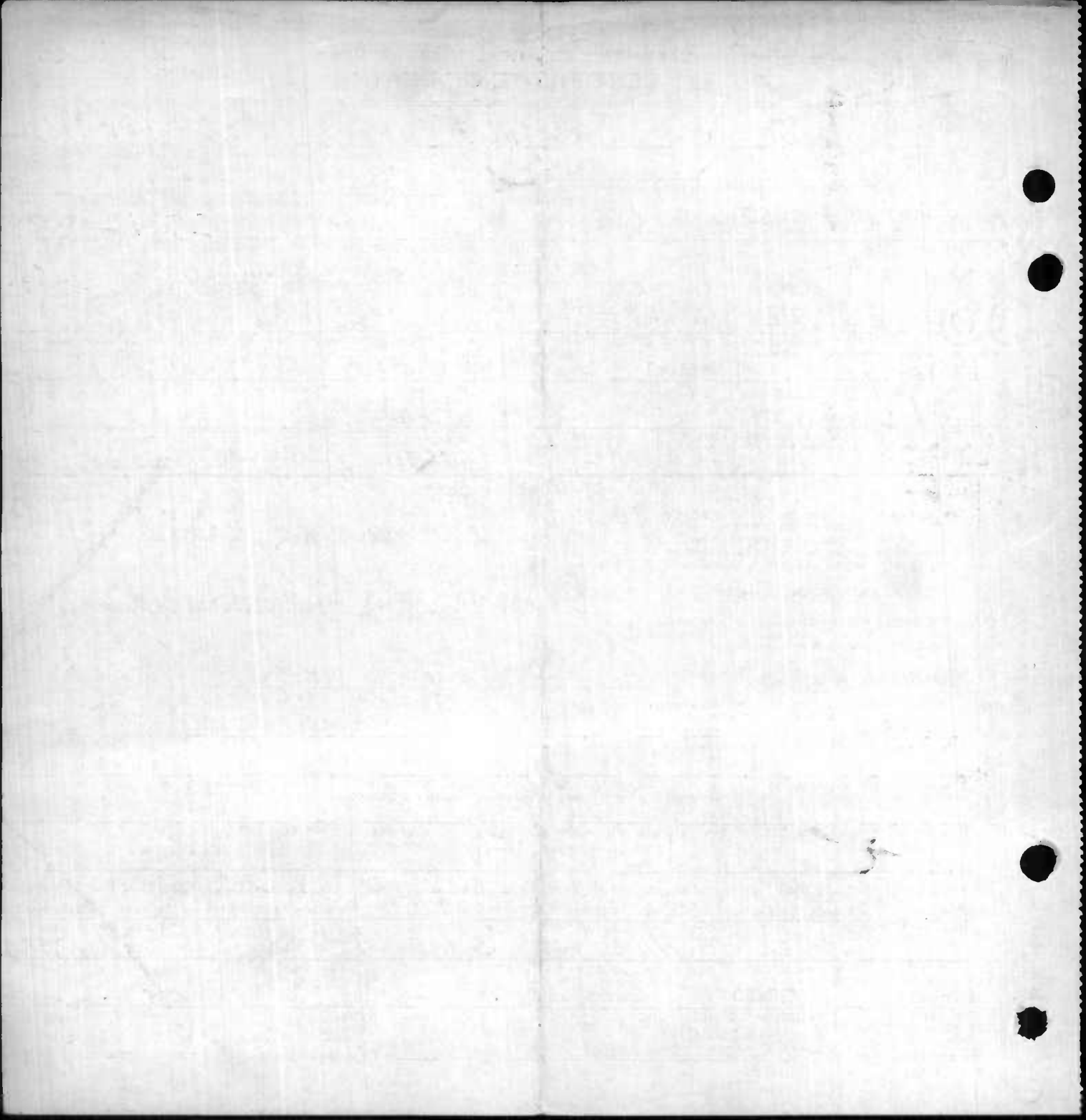
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

William J. Tichenor &amp; Sons, Inc.

ADDRESS





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3823  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Harold C. Ridgely

2. DATE  
OF  
DEATH

April 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

40 St Agnes Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

8-01

D. STREET ADDRESS (If rural, give location)

3208 Cliftmont Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

8-28

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Ridgely

14. MOTHER'S MAIDEN NAME

Anna Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Elizabeth Young

ADDRESS

1647 Mussula Rd.

1B. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) HYPERTENSIVE ARTERIAL-  
DUE TO SCLEROTIC CARDIO-VASCULAR  
DISEASE & CORONARY FAILURE  
(B) MYOCARDIAL INFARCTION  
DUE TO  
(C) TERMINAL UREMIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/11, 1950 to 4/24, 1950, that I last saw the  
deceased alive on 4/24, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 25 1950

Huntington Williams, M.D.

WILLY &amp; ZEILER, INC. BALTO-

VS 150

93D

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Hemlock

Hemlock

Hemlock

Hemlock

Hemlock

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BERMENDER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3824

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Julia Bermender*2. DATE  
OF  
DEATH*April 23, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*419 Evesham Ave.*

c. Length of stay in Baltimore

5. SEX

*F.*

6. COLOR OR RACE

*W.*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*M.*

8. DATE OF BIRTH

*July 29 - 97*9. AGE (In years  
last birthday)*52*10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work denoting most of working life, even if retired)*Housewife*10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore, Md.*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*George Anthony*

14. MOTHER'S MAIDEN NAME

*Mary Rupp*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Horace Z. Bermender, 3627 Green -*18. *180 X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

*Hypertension, neglect -*INTERVAL BETWEEN  
ONSET AND DEATH*3 yr.*

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Mar. 17, 1950*, to *April 23, 1950*, that I last saw the  
deceased alive on *April 22, 1950*, and that death occurred at *5:05 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Adam Glavis*

M. D.

23B. ADDRESS

*6232 Belair Rd*

23C. DATE SIGNED

*April 25, 1950*24A. BURIAL, CREMA-  
TION (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

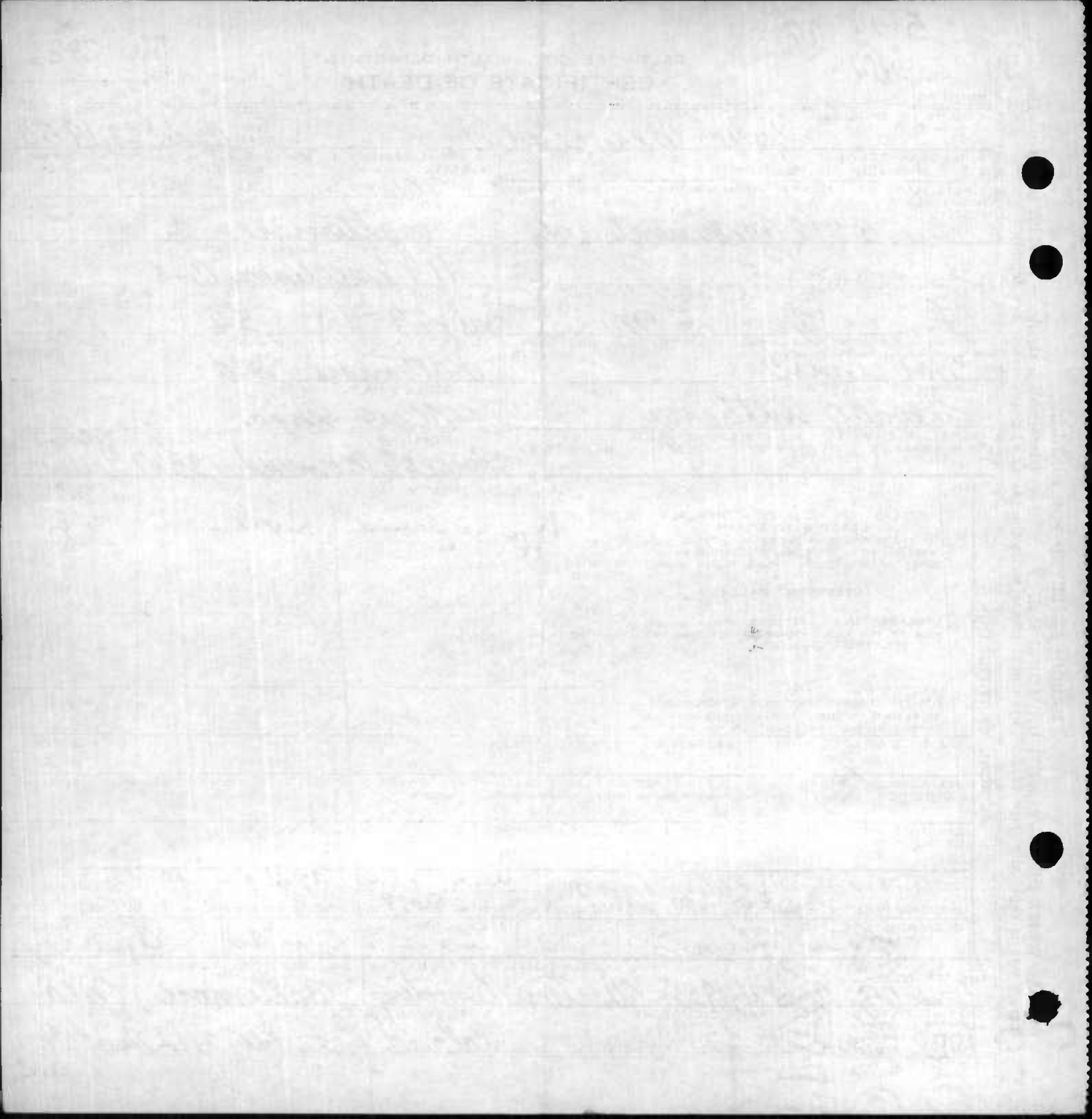
*Burial April 26, 1950 Western Cemetery Baltimore, Md.*DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*APR 25 1950**Wilmington Williams, Md.**Roland P. Fisher, 2112 Dundalk*



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3825

1. NAME OF DECEASED  
(Type or Print)

Cynthia Clarke

2. DATE  
OF  
DEATH

April 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Bed. HLH 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

before admission)

Md. Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Harundale 5200

D. STREET ADDRESS (If rural, give location)

1801 Saunders Way

c. Length of stay in Baltimore

13

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

2-8-47

9. AGE (In years last birthday)

3

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Karl L. Clarke

14. MOTHER'S MAIDEN NAME

Nannette Nancy C. Johnston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

592 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Nephritis, chronic

INTERVAL BETWEEN ONSET AND DEATH

18 mos.

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-11-1950 to 4-24-1950, that I last saw the deceased alive on 4-24-1950, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas C. McPerson M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

April 24, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 25 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John O. Mitchell &amp; Sons, Inc. 1900 Eutaw Pl.

ADDRESS







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3826

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ALEXANDER P. JAMES

2. DATE  
OF  
DEATH

4/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-19

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)

2504 Manhattan Ave #15

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

7-27-72

9. AGE (In years last birthday)

77

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer - retired

10B. KIND OF BUSINESS OR INDUSTRY

Steamboat

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Thomas James

14. MOTHER'S MAIDEN NAME

Margaret B. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. Mildred Forero 2504 Manhattan Ave.

18.

592 X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Uremia

ANTECEDENT CAUSES

(B)

DUE TO

Chronic nephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

DUE TO

and Diabetes mellitus

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, Diverticulitis, neoplastic rectal mass

INTERVAL BETWEEN ONSET AND DEATH

50 years?

50 years?

?

?

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-12-1950 to 4-24-1950 that I last saw the deceased alive on 4/24-1950 and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

4/27/50

Druid Ridge Cem.

Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 25 1950

Huntington Williams, Jr.

Wm. C. Pickner &amp; Sons Balto Md.

VS 150

61



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3827  
Registered No. 50 3827

K-410  
50 3827  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY E. KALB</b>			2. DATE OF DEATH <b>Apr. 25, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>222 N. Monroe Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 20-01</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>222 N. Monroe St.</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>March 24, 1871</b>		9. AGE (In years last birthday) <b>79</b> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John B. Kalb</b>			14. MOTHER'S MAIDEN NAME <b>Augusta Lauzendoerfer</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT ADDRESS <b>Miss Augusta A. Kalb 222 N. Monroe St.</b>		

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis Heart Disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerosis</b> DUE TO		
(C) <b>Hematuria Cause Undet.</b> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 1, 1947</b> , to <b>Apr 25, 1950</b> , that I last saw the deceased alive on <b>4/25, 1950</b> , and that death occurred at <b>3 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>J. Mendelis</b> M. D.		23B. ADDRESS <b>651 N. Bentallon</b>		23C. DATE SIGNED <b>4/25/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/28/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Viehner &amp; Sons Baltimore, Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 25 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>			



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3828BIRTH NO. 50-083421. NAME OF DECEASED  
(Type or Print) Baby Boy Rose2. DATE  
OF  
DEATH 4/25/503. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE 42 Sinai HospitalC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 15-05

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)  
2002 Calo Ave5. SEX M6. COLOR OR RACE W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify) S8. DATE OF BIRTH 4/25/509. AGE (In years last birthday) 0 0 3 1510. Under 1 Year Months Days  
11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
Mathew14. MOTHER'S MAIDEN NAME  
Evelyn15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT  
Mathew RoseADDRESS  
2002 Calo Ave18. 776 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
Prematurity

(A) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/25, 1950 to 4/25, 1950 that I last saw the deceased alive on 4/25, 1950 and that death occurred at m., from the causes and on the date stated above.23A. SIGNATURE  
Edwin Green23B. ADDRESS  
Sinai Hospital23C. DATE SIGNED  
4/25/5024A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial24B. DATE  
4-25-5024C. NAME OF CEMETERY OR CREMATORY  
Hebrew Friendship24D. LOCATION (City, town, or county) (State)  
Balto MdDATE RECEIVED BY LOCAL REGISTRAR  
APR 25 1950REGISTRAR'S SIGNATURE  
Huntington Williams, M.D.25. FUNERAL DIRECTOR  
Jack Lewis IncADDRESS  
2100 Eustaw Rd







H 543 ES-137423

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3829  
Registered No.

BIRTH NO. 50-07826

1. NAME OF DECEASED (Type or Print) Baby Boy Hamilton-Dorothy			2. DATE OF DEATH 4-19-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 542 Baker Street (17)		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 4-19-50	9. AGE (In years last birthday) 7	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Hamilton			14. MOTHER'S MAIDEN NAME Dorothy Mae Madden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS 4940 Records* Balto. City Hospitals Eastern Ave		

## MEDICAL CERTIFICATION

18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Prematurity DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-19, 19 50, 4-19, 19 50, that I last saw the deceased alive on 4-19, 19 50, and that death occurred at 1:45 P. from the causes and on the date stated above.			
23A. SIGNATURE J. S. Hogan		23B. ADDRESS M. D. 4940 Eastern Avenue	23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated	24B. DATE 4-21-50	24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory	24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave.
DATE RECEIVED BY LOCAL REGISTRAR APR 25 1950		REGISTRAR'S SIGNATURE W. H. Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS

STATE OF NEW YORK  
CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3830

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John M. Phoebus

2. DATE  
OF  
DEATH

4-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 N. Carey St.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Wid.

8. DATE OF BIRTH

Sept. 27, 1869

9. AGE (In years  
last birthday)

80

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Contractor

10B. KIND OF BUSINESS OR  
INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Phoebus

14. MOTHER'S MAIDEN NAME

Martha Leakins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic Heart Disease

cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

(C) Bronchopneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from 10-6-49, 19, to April 24, 1950 that I last saw the deceased alive on April 24, 1950, and that death occurred at 5.20AM., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Cohen

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-24-50

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

April 26, 1950

Morgan Chapel Cemetery

CARROLL County Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 25 1950

Huntington Williams, M.D.

Geo. L. Schwab 2101 Frederick Ave.



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Mary Smith</b>		2. DATE OF DEATH <b>4-25-1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1426 E. Madison St</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>MD</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Md. 10-02</b>	
C. Length of stay in Baltimore <b>1.4c</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1426 E. Madison St</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>10-6-1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Medley</b>		14. MOTHER'S MAIDEN NAME <b>Serina Landsdale</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT (Sister) <b>Corea Roy Jones</b>		ADDRESS <b>1426 E. Madison St</b>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Carcinoma (stomach)</b> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>hypertensive cardio-renal disease</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 1949</b> to <b>April 25, 1950</b> , that I last saw the deceased alive on <b>4/23</b> , 1950, and that death occurred at <b>12:30</b> A. M., from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>500 EAST BROWN ST BALTIMORE, MD</b>		23C. DATE SIGNED <b>4-25-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/27/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Ceme</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 26 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Fattie Grace</b>		ADDRESS <b>1408 Ashland Ave.</b>	

VS 150

46B

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VALLEY  
GOLF COURSE

1905

1906

1907

1908

1909

1910

1911

1912

1913

1914

1915



W-4 52  
50 3832

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3832  
Registered No.

BIRTH NO. 50-07771

1. NAME OF DECEASED  
(Type or Print)

*Jacqueline Bonita William*

2. DATE OF DEATH

*4/19/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Maryland*

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*Provident Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 18-02*

C. Length of stay in Baltimore

*3*

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

*517 N. Carey St.*

5. SEX

*Female*

6. COLOR OR RACE

*Negro*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

*4/17/20<sup>50</sup>*

9. AGE (In years last birthday)

10. Under 1 Year

11. Under 24 Hours

Months Days Hours Min.

*3*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore Md*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Harlie James William*

14. MOTHER'S MAIDEN NAME

*Miriam Bridgetts*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

*Mother*

ADDRESS

18. 773.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Acute Respiratory failure*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

*Weak Gastrointestinal  
distention (atony)*

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *4/17* 19*50*, to *4/19* 19*50*, that I last saw the deceased alive on *4/19* 19*50*, and that death occurred at *4:45* p. m., from the causes and on the date stated above.

23A. SIGNATURE

*Dr. H. P. Pennington M.D.*

23B. ADDRESS

*Provident Hosp.*

23C. DATE SIGNED

*4-20-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL APR 24 1950

DATE RECEIVED BY REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Commissioner of Health*

APR 25 1950

*Wilmington, Delaware*

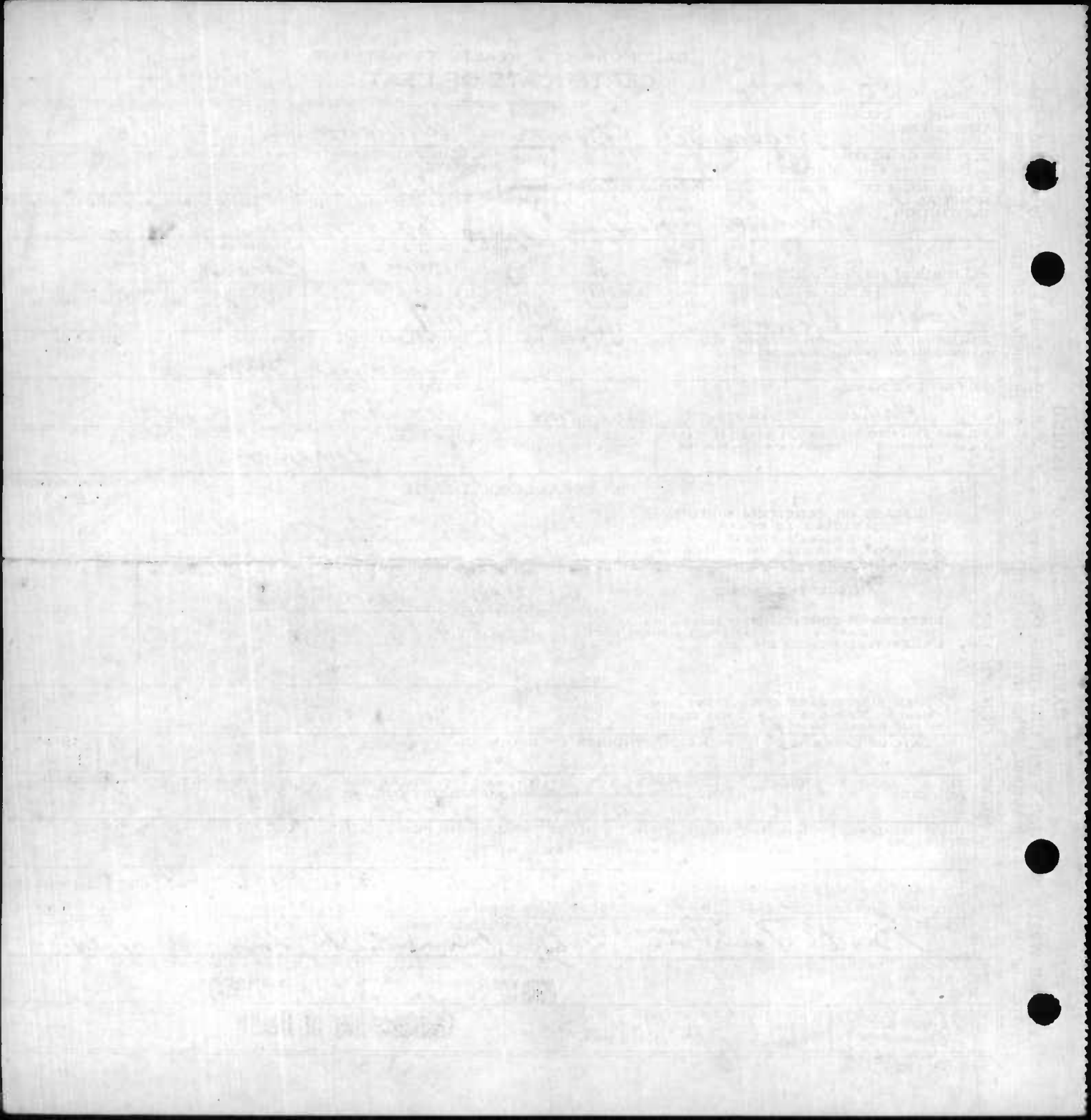
APR 25 1950

APR 26 1950

123

MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-08044

50 3833

1. NAME OF DECEASED  
(Type or Print)

Sands, Baby Boy

2. DATE  
OF  
DEATH

4-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

51 North Ship Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

35 Church Home &amp; Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE MD.

D. STREET ADDRESS (If rural, give location)

Dundalk 5300

c. Length of stay in Baltimore

26 1/2 hrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

4-21-50

9. AGE (In years last birthday)

0

H Under 1 Year Months: Days

0

H Under 24 Hours Hours: Min.

1

2

30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Sands, Mr. Leonnel

14. MOTHER'S MAIDEN NAME

Lemley, Nellonloc

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Parents

ADDRESS

51 Northship Road, Balto.

18. 7625

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia secondary to atelectasis

None

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity (Birth wt. = 4 lbs. 10 ozs.)

None

DUE TO

(C) -

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

-

20. AUTOPSY?

YES ☒NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

No

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

-

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

-

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

-

22. I hereby certify that I attended the deceased from April 22, 1950 to April 23, 1950 that I last saw the deceased alive on April 23, 1950, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Karl Moore

M. D.

23B. ADDRESS

Church Home &amp; Hospital

23C. DATE SIGNED

4-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

at \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50-084091. NAME OF DECEASED  
(Type or Print)Mary Helen BEESON2. DATE  
OF  
DEATHApril 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE MD. B. COUNTY Farmington

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Volunteers of America Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - 31 6-03

C. Length of stay in Baltimore

1 1/2 hoursYrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2109 E. Farmington Ave

5. SEX

M

6. COLOR OR RACE

W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

April 21, 19509. AGE (in years;  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.1 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto, Md.12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

GAWEN15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Helen Beeson 2109 E. Farmington Ave18. 776.X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) .....

Extreme prematurity90 minutes

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) .....

DUE TO

## II

(C) .....

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 21, 1950, to April 21, 1950, that I last saw the deceased alive on April 21, 1950, and that death occurred at 4:15 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Reynard Jones

M. D.

23B. ADDRESS

Volunteers of America Hosp.

23C. DATE SIGNED

4/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL APR 24 1950DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

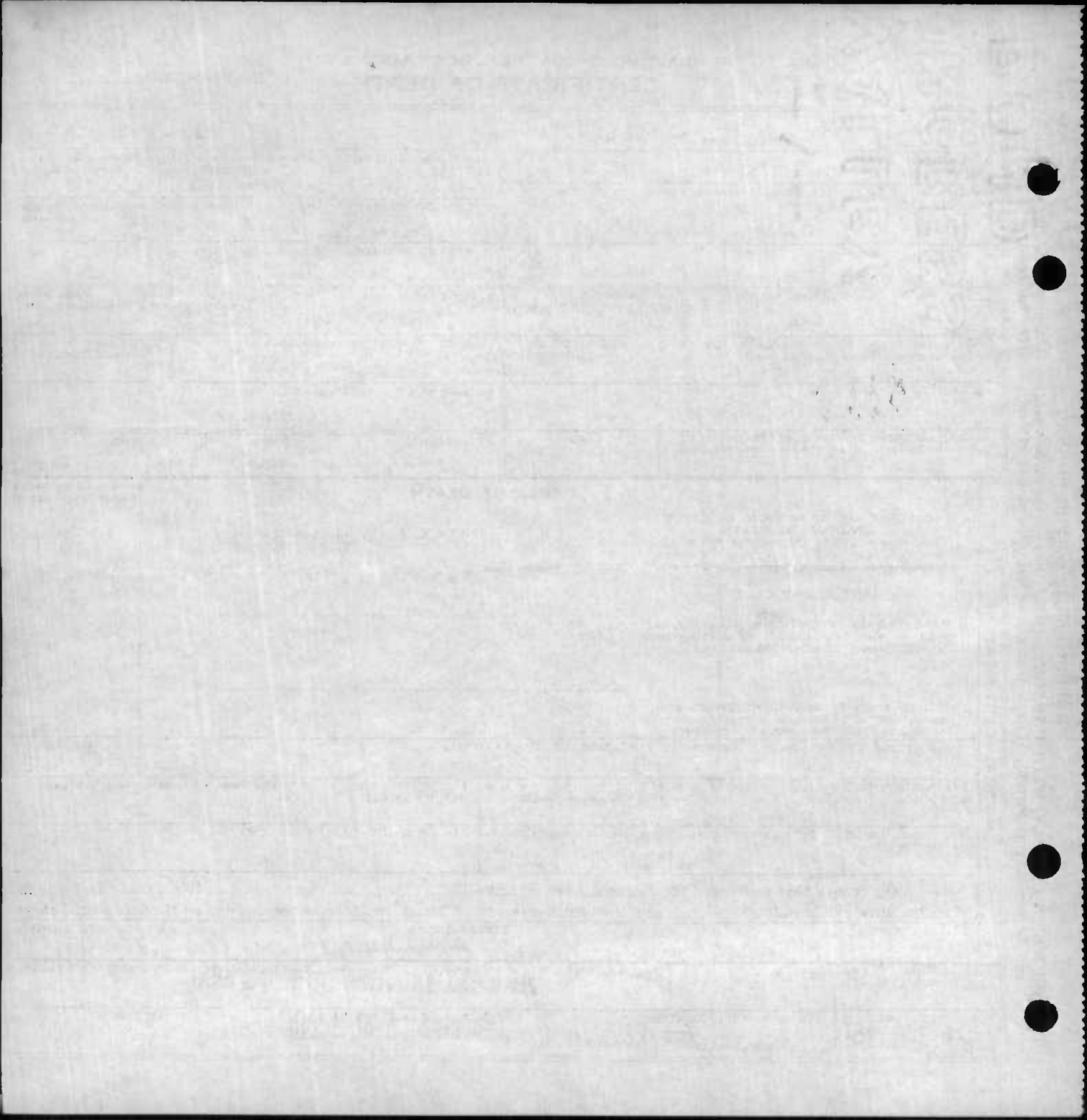
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

APR 26 1950







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3835

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Samuel Rothman

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE 4532 Pimlico Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 27-16

D. STREET ADDRESS (If rural, give location)

4532 Pimlico Road

c. Length of stay in Baltimore

30 yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

1887

9. AGE (In years,  
last birthday)

62

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Tailor Own Business10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?  
USA.

13. FATHER'S NAME

Hyman Rothman

14. MOTHER'S MAIDEN NAME

Leah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

Yetta Rothman

ADDRESS

4532 Pimlico Road

18. 420.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) arterio-sclerotic cardio-vascular disease  
general arterio-sclerosis  
(B) coronary occlusion  
arterio-sclerosis  
(C)INTERVAL BETWEEN  
ONSET AND DEATH1 year  
4 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/16, 1949, to 4/25, 1950, that I last saw the deceased alive on 4/25, 1950, and that death occurred at 7 A. m., from the causes and on the date stated above.

23A. SIGNATURE

12-C. Nicholson

M. O.

23B. ADDRESS

2230 Eutaw Place

23C. DATE SIGNED

4-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Chizuk Amuno Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 26 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Sol Lerman + Bros

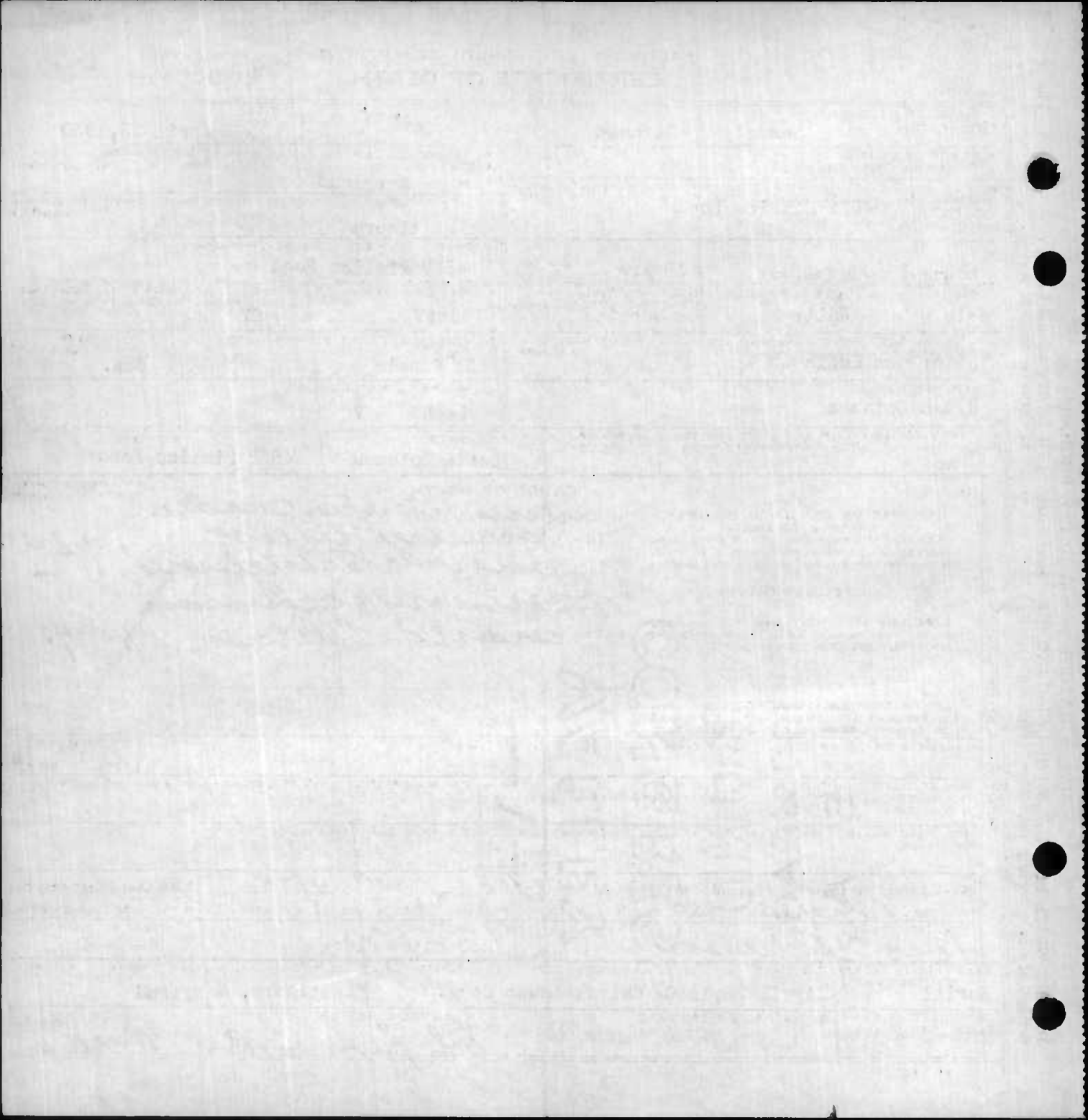
ADDRESS

1126 W North Ave

VS 150

36065

937



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3836

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES - THOMPSON

2. DATE  
OF  
DEATH

APRIL 24, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

BALTO CITY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1611 Holbrook St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 9-09

D. STREET ADDRESS (If rural, give location)

1611 Holbrook St.

c. Length of stay in Baltimore

20

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 15, 1880

9. AGE (In years last birthday)

69

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Rent collector

10B. KIND OF BUSINESS OR INDUSTRY

Rent from houses

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Thompson

14. MOTHER'S MAIDEN NAME

Susan Gaither

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Hattie Thompson 1611 Holbrook St.

18. 470.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

26 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Anterograde C-V disease

5 years

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 29, 1950 to April 24, 1950 that I last saw the deceased alive on April 22, 1950, and that death occurred at 10 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. H. Greener

M. D.

23B. ADDRESS

1520 E. 33rd St.

23C. DATE SIGNED

4-24-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial  
DATE RECEIVED BY LOCAL REGISTRAR

24B. DATE

Apr. 26, 1950

24C. NAME OF CEMETERY OR CREMATORIUM

Mt View

24D. LOCATION (City, town, or county)

Alpha - Howard - Md.

(State)

REGISTRAR'S SIGNATURE

Wm. H. Greener

25. FUNERAL DIRECTOR

C. H. Wilson

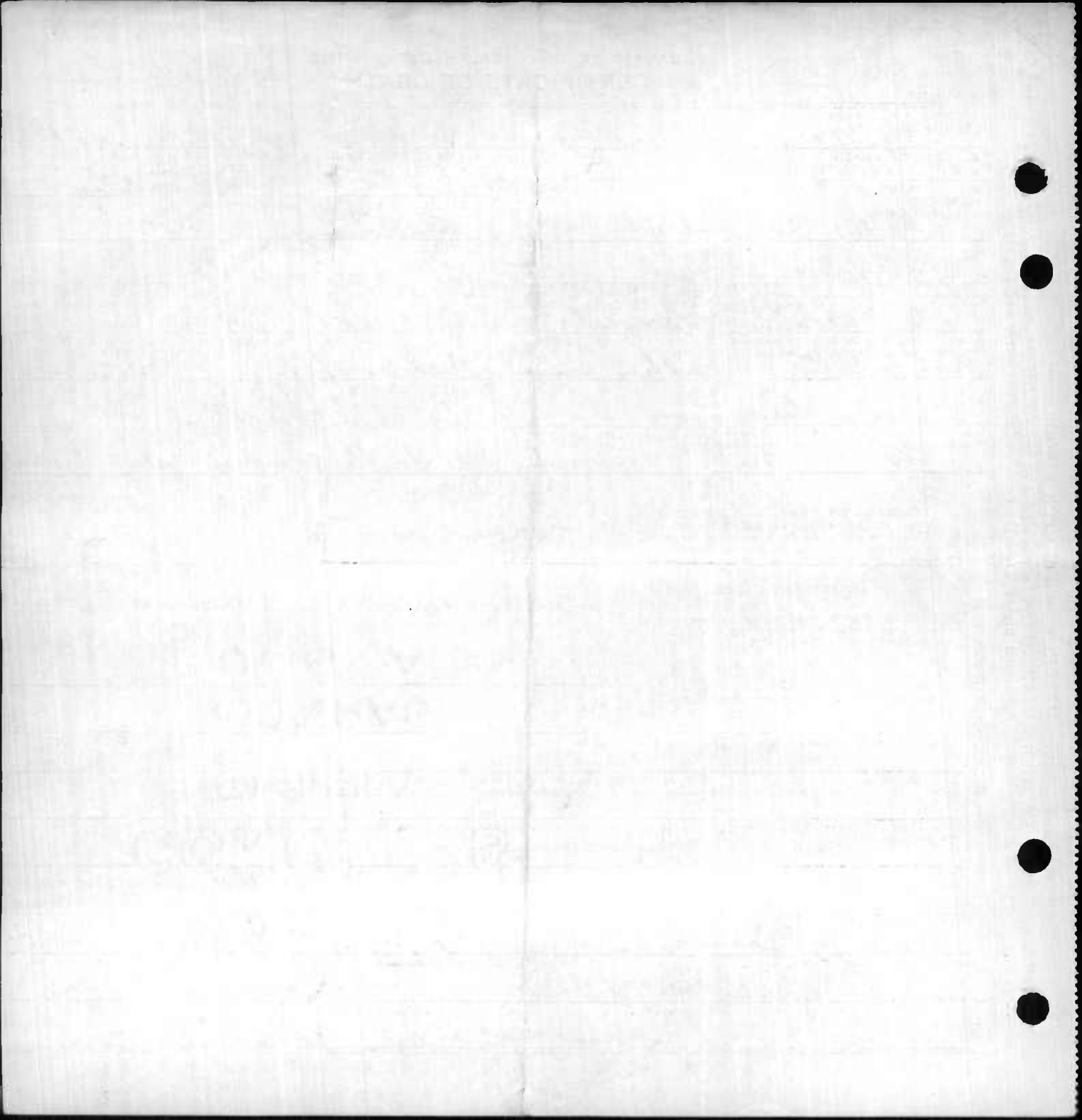
ADDRESS

Lynchville, Md.

APR 26 1950  
VS 150

276A/

93D



PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET A. WOLFE

2. DATE  
OF  
DEATH

4/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

46 WEST BALTO GEN HOSP

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto 14-01

D. STREET ADDRESS (If rural, give location)

1615 Linden Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10/11/1896

9. AGE (In years  
last birthday)

53

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Penna

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Roy S. Wolfe 1615 Linden Ave

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebrovascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive arteriosclerosis

DUE TO

Heart Disease

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Lid to mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21, 1950, to 4/24, 1950, that I last saw the  
deceased alive on 4/24, 1950, and that death occurred at 7:40 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 26 1950

Christington Williams, M.D.

H. Horn 1219 St Paul

STANDARD FORM NO. 64

STANDARD FORM NO. 64

STANDARD FORM NO. 64

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STANDARD FORM NO. 64

STANDARD FORM NO. 64



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3838

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George J. Smith

2. DATE  
OF  
DEATH

Apr. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMATION ADDRESS

18. 023X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Aortic insufficiency with  
heart failure -

several  
months

ANTECEDENT CAUSES

(B)

DUE TO

Cardiovascular system  
syphilis

many  
years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of prostate

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

22. I hereby certify that I attended the deceased from 7/11, 1950, to 4/25, 1950, that I last saw the deceased alive on 4/25, 1950, and that death occurred at 9:21 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3839

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles J. Neill

2. DATE  
OF  
DEATH

4/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

24-04

D. STREET ADDRESS (If rural, give location)

1634 Covington Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

SEPT-12-1885

9. AGE (In years  
last birthday)

65

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR  
INDUSTRY

NEVER WORKED

13. FATHER'S NAME

James Neill

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U S

14. MOTHER'S MAIDEN NAME

Theresa Denise DEMEK

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

JAMES J. NEILL, 429 E GITTINS ST.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertension

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Kyphoscoliosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/24, 1950 to 4/25/50, 19, that I last saw the deceased alive on 4/25, 1950, and that death occurred at 3:55 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 26 1950

Baltimore, Md.

Bernard C. Hulse 1215 West St

STATE OF TEXAS

91

DEPARTMENT OF HEALTH  
STATE OF TEXAS

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

50 3840  
 Registered No.

BIRTH NO.

1. NAME OF DECEASED  
 (Type or Print)

Mr. Gerald Reville

2. DATE  
 OF  
 DEATH

4-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Bon Secours Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

28-04

D. STREET ADDRESS (If rural, give location)

4223 Euclid Ave., Irvington.

c. Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

5-9-1889

9. AGE (In years last birthday)

67 (63)

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

CHOCOLATE BAKERY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

PETER REVILLE

14. MOTHER'S MAIDEN NAME

Eliza Donohoe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

818-07-0409 JOHANN REVILLE 4223 EUCLID AVE

17. INFORMANT

ADDRESS

18. 541.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Bleeding from y. I. Tract.

ANTECEDENT CAUSES

(B)

Peptic Ulcer.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

Extra renal Azothemia

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23 - 1950 to 4-25 - 1950, that I last saw the deceased alive on 4-25 - 1950, and that death occurred at 1:10 A. M., from the causes and on the date stated above.

23A. SIGNATURE

@. J. Castulano

M. D.

23B. ADDRESS

Bon Secours Hosp.

23C. DATE SIGNED

4-25-50.

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4-28-50

24C. NAME OF CEMETERY OR CREMATORY

CATHEDRAL CEM

24D. LOCATION (City, town, or county)

BALTO

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 26 1950

REGISTRAR'S SIGNATURE

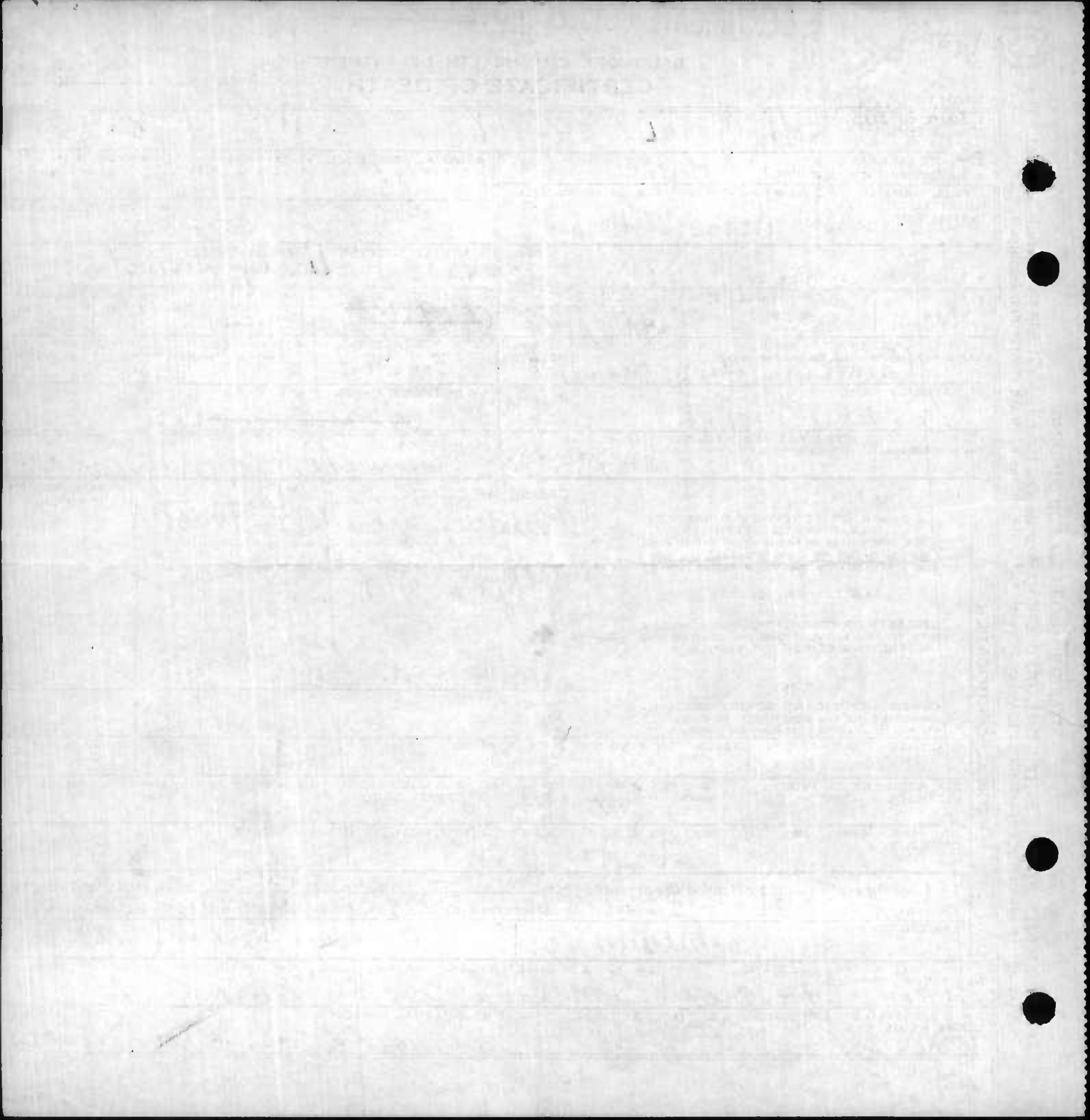
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Bernard B. Harte 1216 West St

ADDRESS







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3841

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH A. COFFAY

2. DATE  
OF  
DEATH

4/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3005 Abell Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Md. 12-02

D. STREET ADDRESS (If rural, give location)

3005 Abell Ave

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 15 1884

9. AGE (In years last birthday)

65

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

at home

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

William Coffay

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Mary Dougherty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Catherine A. Gallagher

3005 Abell Ave.

18.

420.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Atrophic Arteriosclerosis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

C. P. Lombardi

23B. CHIEF MEDICAL EXAMINER

M.D.

23C. DATE SIGNED

ASSISTANT MEDICAL EXAMINER

4/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Chas. G. Evans &amp; Son, Inc.

118 N. Mt. Royal Ave. 94a

APR 26 1950

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

I, \_\_\_\_\_

do hereby certify that \_\_\_\_\_

was born \_\_\_\_\_

and died \_\_\_\_\_

at \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

at \_\_\_\_\_

and was buried \_\_\_\_\_

at \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

at \_\_\_\_\_

and was buried \_\_\_\_\_

at \_\_\_\_\_

on the \_\_\_\_\_ day of \_\_\_\_\_

19\_\_\_\_

at \_\_\_\_\_

and was buried \_\_\_\_\_

at \_\_\_\_\_

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MICHAEL SMITH

2. DATE  
OF  
DEATH

April 24 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 96-07

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

646 S. Newkirk St

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

10-11-11

9. AGE (In years  
last birthday)

38

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Unknown, unemployed

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Manassas Pa

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Smith

14. MOTHER'S MAIDEN NAME

Mary Estok

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

200-05-1464

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

592X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Uremia

DUE TO

ANTECEDENT CAUSES

(B)

Chronic glomerulonephritis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

4 weeks

Several  
years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/30, 1950, to 5/25, 1950, that I last saw the  
deceased alive on 5/25, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Edw. H. Schaefer, M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

Apr. 25, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

Fairleyville

24D. LOCATION (City, town, or county)

Fairleyville Pa

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

1219 S. Coul St



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3843

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

James

Thompson

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 600 S. Chapelgate Lane

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY Montgomery

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Pinecrest Sanatorium

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Boyd

6500

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

?

8. DATE OF BIRTH

1878

9. AGE (In years  
last birthday)

72

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Calvin Thompson

14. MOTHER'S MAIDEN NAME

Dora Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Hospital Records

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) CHRONIC MYOCARDITIS AND  
MYOCARDIAL DEGENERATION

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

? years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Generalized Arteriosclerosis ? years

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Malnutrition due to Refusal of Food

4 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 15, 1950, to April 25, 1950, that I last saw the  
deceased alive on April 25, 1950, and that death occurred at 10:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Melvin N. Borden

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

4/25/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-28-50

24C. NAME OF CEMETERY OR CREMATORY

Forest Oak

24D. LOCATION (City, town, or county)

Gaithersburg, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Hilton, Barnesville, Md.

STATE OF TEXAS  
CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

1

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

1



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. **50 3844**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)**MATTHEW. G. HAMMER**2. DATE  
OF  
DEATH**April 24, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**MD.**

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

**242 S. EATON ST**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**BALTO 26-08**

D. STREET ADDRESS (If rural, give location)

**242 S. EATON ST**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**M**

6. COLOR OR RACE

**W.**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)**DIVORCED**

8. DATE OF BIRTH

**JULY 3, 1884**

9. AGE (In years last birthday)

**65**

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**MEAT WORKER**

10B. KIND OF BUSINESS OR INDUSTRY

**ESSKAY PACKERS**

11. BIRTHPLACE (State or foreign country)

**BALTO. MD**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**JOHN HAMMER**

14. MOTHER'S MAIDEN NAME

**LOUISA SCHNEIDER**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**NO**

16. SOCIAL SECURITY NO.

**213-05-2519**

17. INFORMANT

ADDRESS

**Mrs. ALTVATER - 242 S. EATON ST**

18.

**332X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

**Cerebral Thrombosis**

DUE TO

ANTECEDENT CAUSES

(B)

**ant Schen**

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

**1 day**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4/18, 1950**, to **4/24, 1950**, that I last saw the deceased alive on **4/24, 1950**, and that death occurred at **9:00 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

**John G. Hammer**

M. D.

23B. ADDRESS

**3400 E. Belair**

23C. DATE SIGNED

**4/25/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**BURIAL**

24B. DATE

**4/26/50**

24C. NAME OF CEMETERY OR CREMATORY

**HOLY REDEEMER**

24D. LOCATION (City, town, or county)

**Belair Rd Balto, Md**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

ADDRESS

**Mildred J. Blight, 6009 Harford**

Dr. Goodman.  
3600 E BALTO.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-3450 3845

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3845

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Martha Wheatley</i>		2. DATE OF DEATH <i>Apr. 25, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Md</i> B. COUNTY			
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i> <i>33</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-99</i>			
6. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>1501 Northwick Rd</i>			
7. SEX <i>Female</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	10. DATE OF BIRTH <i>2-14-94</i>	11. AGE (In years last birthday) <i>56</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ass't buyer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Fur store</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>John B. Nickel</i>		14. MOTHER'S MAIDEN NAME <i>Anna ?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-01-2119</i>		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS	

18. <i>201X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Angina's Pectoris</i>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Uremia</i>		
(B) DUE TO		
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/7</i> , 19 <i>50</i> , to <i>4/25</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>4/25</i> , 19 <i>50</i> , and that death occurred at <i>m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Walter A. ...</i> M. D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>4/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>4/28/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Western Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, Md.</i>		25. FUNERAL DIRECTOR <i>HENRY SANDER &amp; SONS, INC.</i> <i>NORTH AVE. &amp; BROADWAY - 13</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 26 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>		ADDRESS	

*12065 Cecile L. Hill*

*44 B*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3846  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**ALVERNON C. WELLS**

2. DATE  
OF  
DEATH

**Apr. 24, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

**Maryland**

B. COUNTY

\_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**1214 E. North Avenue**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

**9-08**

D. STREET ADDRESS (If rural, give location)

**1214 E. North Avenue**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**M**

6. COLOR OR RACE

**W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Married**

8. DATE OF BIRTH

**Sept. 29, 1869**

9. AGE (in years last birthday)

**80**

10. Under 1 Year Months: Days: 11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Glass cutter-ret.**

10B. KIND OF BUSINESS OR INDUSTRY

**Swindell Bros,**

11. BIRTHPLACE (State or foreign country)

**New Jersey**

12. CITIZEN OF WHAT COUNTRY?

**USA**

13. FATHER'S NAME

**Thomas Wells**

14. MOTHER'S MAIDEN NAME

**Catherine Paine**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

**no**

16. SOCIAL SECURITY NO.

**218-09-1882**

17. INFORMANT

**2908 Dunbrin Road  
Alvernon Wells, Jr.**

18.

**450.1**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Generalized arteriosclerosis**  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO  
(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Gangrene of left leg  
Coronary arteriosclerosis**

INTERVAL BETWEEN ONSET AND DEATH

**3 months**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 12, 1950**, to **April 24, 1950**, that I last saw the deceased alive on **April 20, 1950**, and that death occurred at **9:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

**Sol Smith**

23B. ADDRESS

**12232 N. K Ave**

23C. DATE SIGNED

**4/26/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**burial**

24B. DATE

**4/26/50**

24C. NAME OF CEMETERY OR CREMATORY

**Glen Haven**

24D. LOCATION (City, town, or county)

**Baltimore, Md.**

(State)

DATE RECEIVED BY LOCAL REGISTRAR

**APR 26 1950**

REGISTRAR'S SIGNATURE

**Thurston Williams, M.D.**

25. FUNERAL DIRECTOR

**HENRY SANDER & SONS, INC.  
BALTIMORE - 13, MARYLAND**

ADDRESS

VS 150

*Debbie Hill*

97

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MARY ANN DICKINSON

2. DATE  
OF  
DEATH

Apr. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION4702 Harford Rd.  
Harford Nursing Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

218 N. Linwood Avenue

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

Feb. 7, 1858

9. AGE (In years  
last birthday)

92

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

York, Pa.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick Maerz

14. MOTHER'S MAIDEN NAME

Fredericka ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT 220 N. Linwood Avenue  
Mrs. C. Graham

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Coronary Thrombosis

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Cardio

DUE TO

(C)

Vascular Disease

4-Oct-49

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 4-Oct, 1949 to 22-Apr, 1950, that I last saw the  
deceased alive on 22-Apr, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles W. Edmunds

M. D.

23B. ADDRESS

2746 Calameda

23C. DATE SIGNED

24-Apr-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Carmel Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

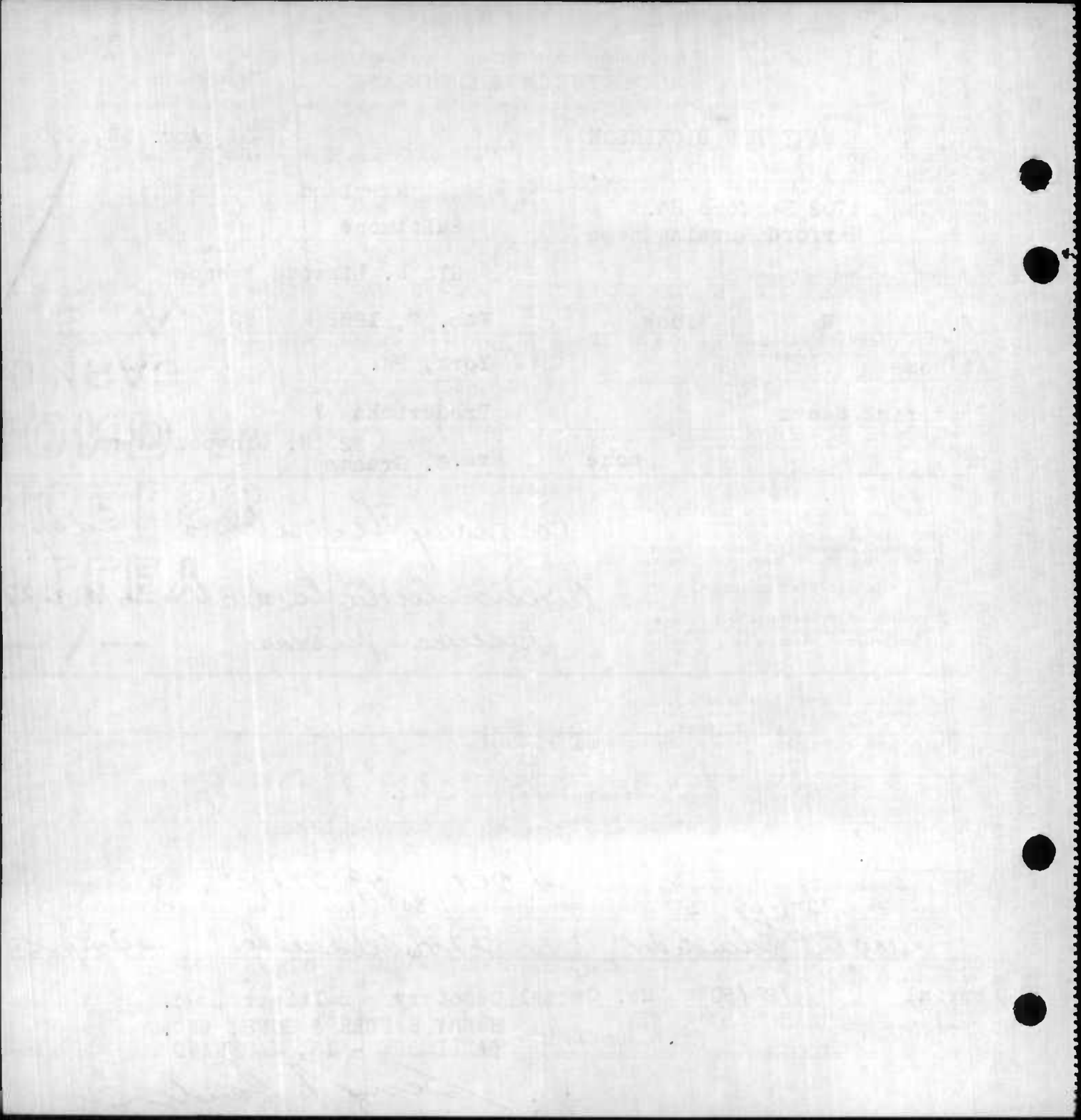
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
BALTIMORE - 13, MARYLAND

ADDRESS

George F. Sander 937



50 3848

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3848

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mary Josephine Kankosky

2. DATE OF DEATH  
April 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 528 N. Belnord Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION  
DO4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md. B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 7-02D. STREET ADDRESS (If rural, give location)  
528 N. Belnord Avenue

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Sept. 4, 1884

9. AGE (In years, last birthday)

65

If Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Vaclav Petr

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Frank Kankosky, Sr., 528 N. Belnord

18. 331X I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PNEUMONIA

DUE TO

10 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CEREBRAL HEMORRHAGE, MULTIPLE

DUE TO

24 hrs

(C) ARTERIOSCLEROSIS + HYPERTENSION

See Pages

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

NONE

19B. MAJOR FINDINGS OF OPERATION

NONE

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

NONE

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

NONE

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

NONE

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

NONE

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

NONE

22. I hereby certify that I attended the deceased from SEPTEMBER, 1947, to 26 APRIL, 1950, that I last saw the deceased alive on 26 APRIL, 1950, and that death occurred at 4:20 m., from the causes and on the date stated above.

23A. SIGNATURE

Charles P. Gentry

23B. ADDRESS

2722 E. Monument St

23C. DATE SIGNED

26 April

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Apr. 29, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

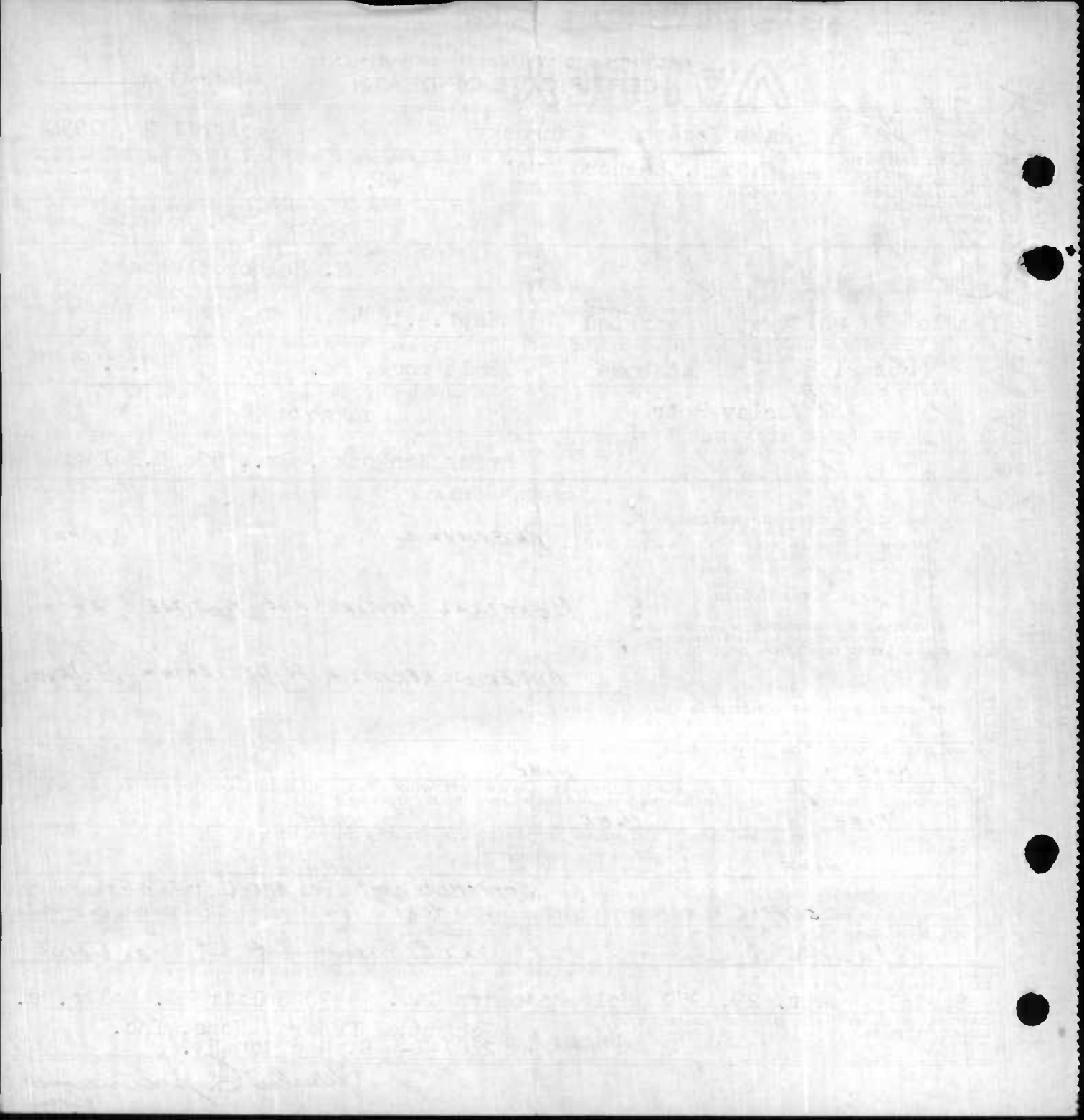
25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601-3-5 E. Madison St.

Charles P. Gentry



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A230 50 3849

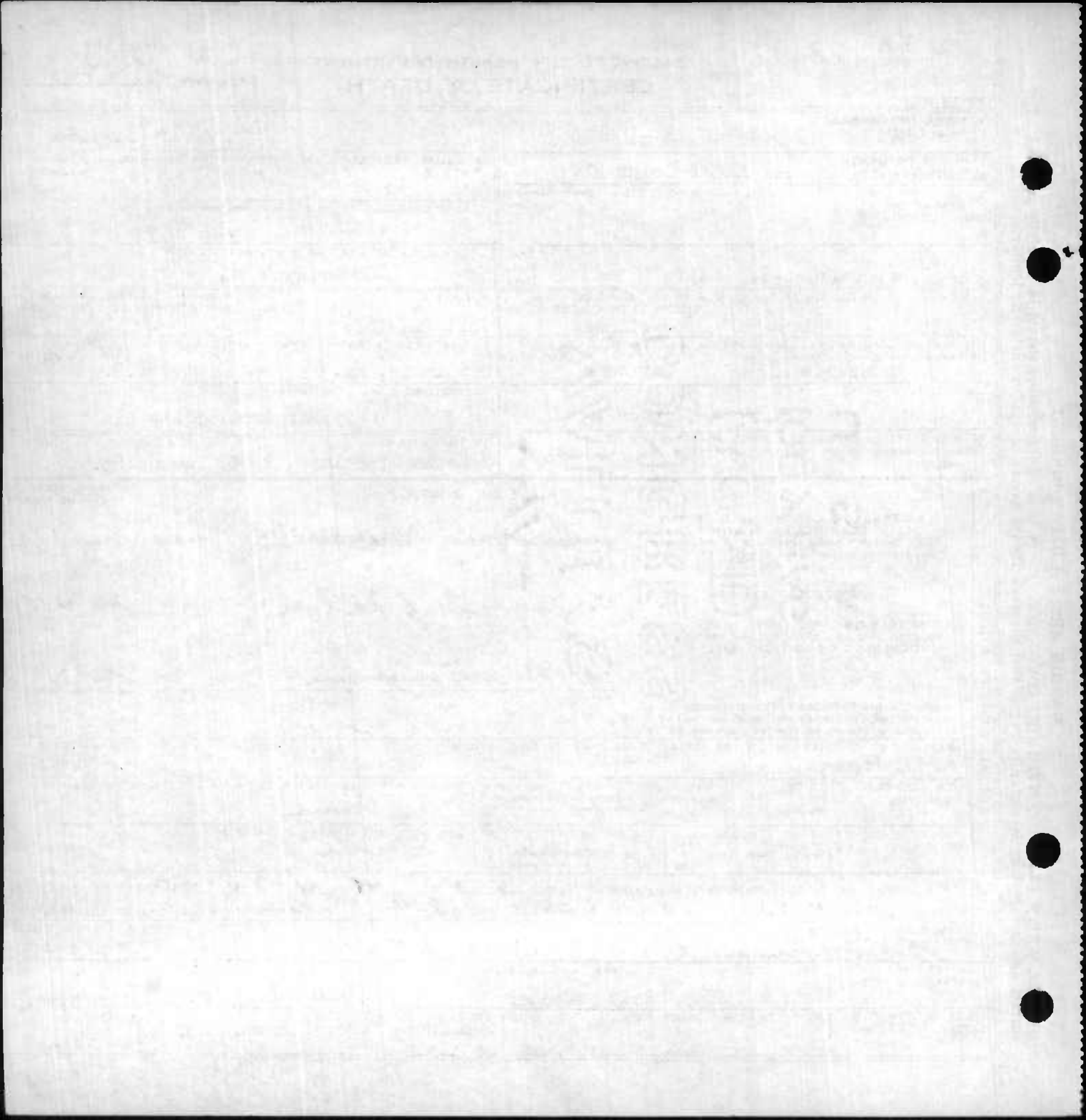
S, 00

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3849  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MARGARET AXT-(SCHAAF)</b>		2. DATE OF DEATH <b>April 24, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2905 Orleans St.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>00</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 6-01</b>	
c. Length of stay in Baltimore <b>life</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2905 Orleans St.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Feb. 22, 1868</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9. AGE (In years last birthday) <b>82</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Fichtner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Margaret Lichtstein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Johanna Michelman, 2905 Orleans St.</b>		ADDRESS	
18. <b>443 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction (C.V. Disease)</b> DUE TO <b>Myocardial Failure</b> DUE TO <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>May 3/40</b> <b>Apr 12/50</b> <b>Apr 20/50</b>	
19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>none</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>	
22. I hereby certify that I attended the deceased from <b>5-3-</b> , 19 <b>40</b> to <b>4-24</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-23-</b> , 19 <b>50</b> , and that death occurred at <b>2:34</b> a. m., from the causes and on the date stated above.			
23A. SIGNATURE <b>E. Schimunek</b> M. D.		23B. ADDRESS <b>842 E. East Ave</b>	
23C. DATE SIGNED <b>4-26-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 27, 1950</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 27 1950</b>		REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2601-3-5 E. Madison St.</b>	

*Charles E. Schimunek* 938





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3850

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BLANCHE DOUGLAS PATTERSON

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3316 Dupont Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3316 Dupont Ave.

c. Length of stay in Baltimore

60 yrs.

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

Sept. 25, 1876

9. AGE (In years  
last birthday)

73 yrs.

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Walter R. Merrifield

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Leonard Patterson - 2822 Riggs Ave.

18.

443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Cerebral Hemorrhage

2 weeks

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

Hypertensive C-V-D

years

(C) ...  
DUE TO

None

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from April 11, 1950, to April 25, 1950, that I last saw the  
deceased alive on April 14, 1950, and that death occurred at 4:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

L. E. Coleman

M. D.

23B. ADDRESS

1201 Poplar Ave St

23C. DATE SIGNED

4-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 26 1950

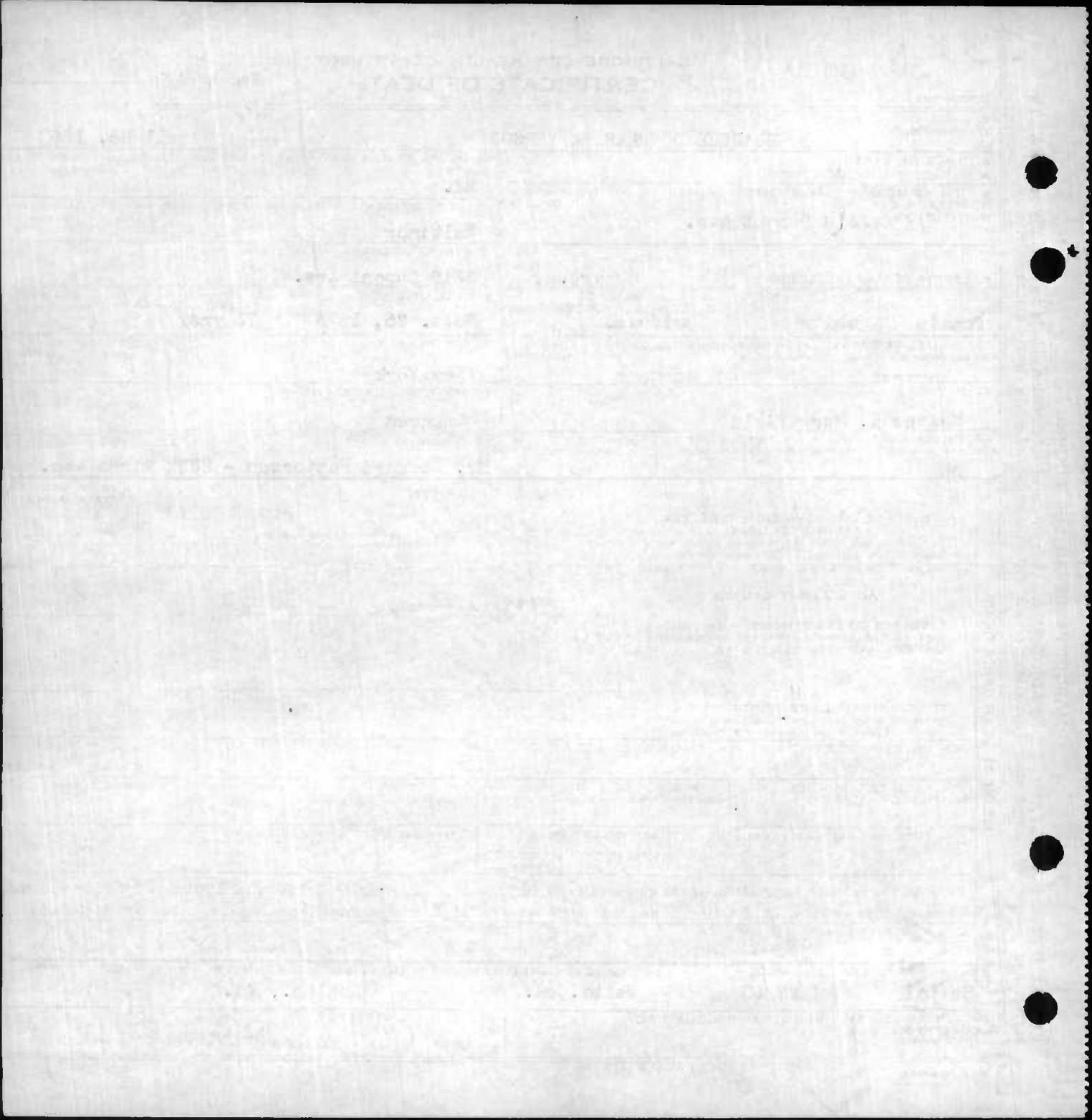
REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Williams &amp; Sons Balto Md.

ADDRESS



MM 137384

50 3851

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3851

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Martin, Webb.

2. DATE  
OF  
DEATH

April 25-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore.

21-02

D. STREET ADDRESS (If rural, give location)

1016 Scott St. Z 30

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 13, 1879

9. AGE (In years

last birthday)

70

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

(DEC)

14. MOTHER'S MAIDEN NAME

(DEC)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL SECURITY NO.  
Unknown

17. INFORMANT

ADDRESS

B.C. H. Records 4940 Eastern Ave.

18.

443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) H A S C V D

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from April 17, 1950, to April 25, 1950, that I last saw the deceased alive on April 25, 1950 and that death occurred at 3:10 AM, from the causes and on the date stated above.

23A. SIGNATURE

H. H. H.

M. O.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

April 25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-28-50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly &amp; Zeiler Co - 403 S. X St.

APR 28 1950

V16 V9

93D

• A •

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 3852**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

**FRANK**

**GOLDSTEIN**

2. DATE  
OF  
DEATH

**April 25, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**University Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

**Baltimore**

**4-02**

D. STREET ADDRESS (If rural, give location)

**125 N. Pine Street**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

**Single**

8. DATE OF BIRTH

9. AGE (In years last birthday)

**55**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Counter man**

10B. KIND OF BUSINESS OR INDUSTRY

**Restaurant**

11. BIRTHPLACE (State or foreign country)

**Baltimore Md**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Louis**

14. MOTHER'S MAIDEN NAME

**Ida**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
**Emmanuel Goldstein 105 N Pine St**

18. **422.1**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial insufficiency**  
DUE TO **arteriosclerotic cardiovascular disease**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inspection & Inquiry** thereon and from **Autopsy, Inspection or Inquiry** the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒, **accident** ☐, **suicide** ☐, **homicide** ☐, **undetermined** ☐.

23A. SIGNATURE

**R. S. Fishers**

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED **4/25/50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

24B. DATE

**4-26-50**

24C. NAME OF CEMETERY OR CREMATORY

**Rosedale**

24D. LOCATION (City, town, or county) (State)

**Balto Md**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, M.D.**

25. FUNERAL DIRECTOR

**Jack Reeves Inc 2100 Century Pl**

ADDRESS

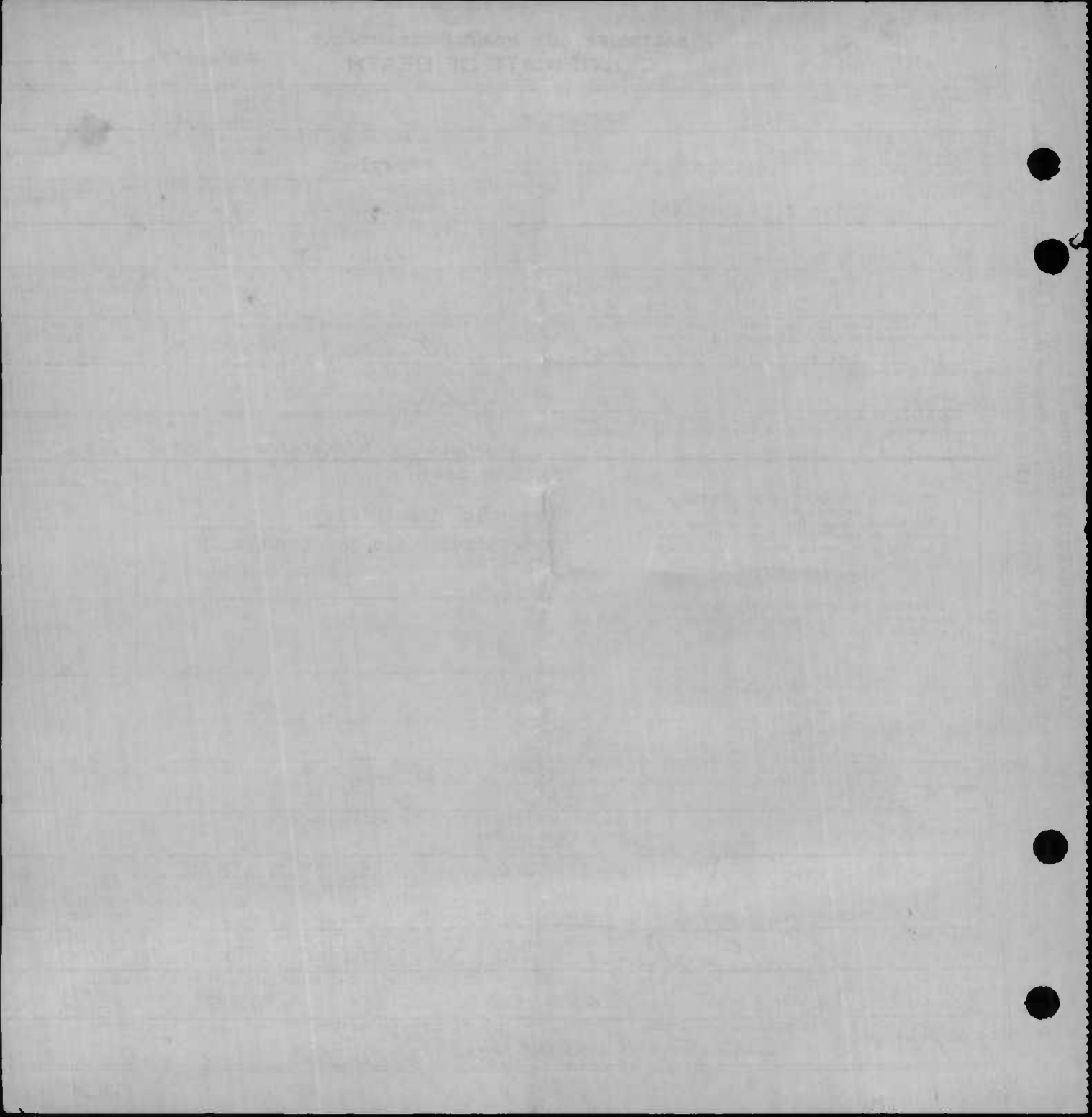
VS 151

**78071**

**937**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

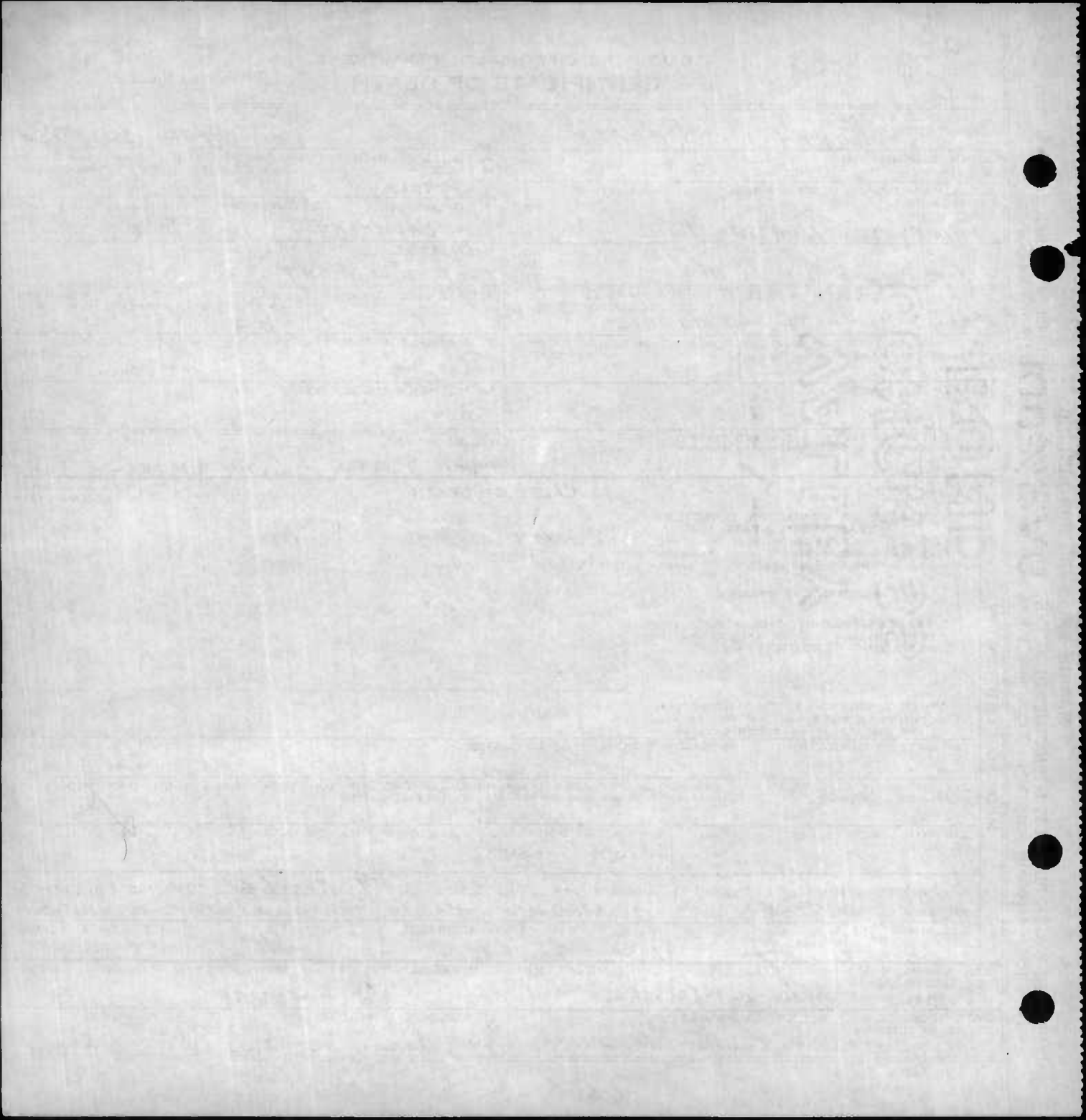




BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3853  
Registered No. \_\_\_\_\_

BIRTH NO. _____			1. NAME OF DECEASED (Type or Print) <b>HARRY V. KRAMER</b>			2. DATE OF DEATH <b>APRIL 25, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____					
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>FEINBLATTS NURSING HOME</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 15-06</b>					
c. Length of stay in Baltimore <b>40</b>			D. STREET ADDRESS (If rural, give location) <b>1701 ELLAMONT ST</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH		9. AGE (in years, last birthday) <b>63</b>	If Under 1 Year Months: Days		If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCCER</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ABRAHAM</b>			14. MOTHER'S MAIDEN NAME <b>DORIS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>SOPHIE KRAMER - 5120 LAUREL AVE.</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-Vascular Disease</b>			CAUSE OF DEATH (A) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO <b>Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension</b>			(B) <b>Hypertension</b> DUE TO <b>Hypertension</b>			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>Dec. 22, 1949</b> to <b>April 25, 1950</b> , that I last saw the deceased alive on <b>4-25, 1950</b> , and that death occurred at <b>2:05 pm.</b> , from the causes and on the date stated above.								
23A. SIGNATURE <b>J. D. [Signature]</b>			23B. ADDRESS <b>11 E. Chase St</b>			23C. DATE SIGNED <b>4-25-50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>APRIL 26, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ROSEDALE</b>		24D. LOCATION (City, town, or county) <b>BALTIMORE</b>		(State) <b>MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 26 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>			25. FUNERAL DIRECTOR ADDRESS <b>Jack Lewis, Inc. 2100 Eutan Place</b>			



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3854  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

OTTO KEVIN

2. DATE  
OF  
DEATH

4-25-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence  
a. STATE b. COUNTY

Md Baltimore 18-01

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

824 W. Baltimore St

c. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 18-01

D. STREET ADDRESS (If rural, give location)

824 W. Baltimore St

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

9. AGE (in years,  
last birthday)

56

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR  
INDUSTRY

Novelty

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Isaac

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS  
Meyer Levin 1028 Cathedral St

18.

420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular 3 years

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1950, to April 23, 1950 that I last saw the  
deceased alive on April 25, 1950, and that death occurred at 4:27 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Harry Shuman

M. O.

23B. ADDRESS

753 W. Fayette St

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4-26-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Young Men

24D. LOCATION (City, town, or county) (State)

Balto Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Eutaw Pl

APR 26 1950

VS 150

27878

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Glasgow  
753 W Fayette St  
1030

---

Correspondence  
Harrison's Bureau of Census

1030  
753 W Fayette St

1030  
753 W Fayette St

M-524

50 3855

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3855

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HENRY W. MANGELS, SR.

2. DATE  
OF  
DEATH4-24-50  
~~1-18-50~~

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

814 BEAUMONT AVE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balt. 27-10

D. STREET ADDRESS (If rural, give location)

814 BEAUMONT AVE

c. Length of stay in Baltimore

77 yrs

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1-3-1873

9. AGE (In years,  
last birthday)

77

If Under 1 Year  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

RETIRED Supt. Coalmin Ships

10B. KIND OF BUSINESS OR  
INDUSTRY

Coalmin Ships

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY MANGELS

14. MOTHER'S MAIDEN NAME

MARGUERITE MANGELS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

216-07-6413

17. INFORMANT

ADDRESS

Marguerite Dutrow 814 Beaumont

18. 450.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral Emboli  
DUE TO

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arteriosclerosis  
DUE TO

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.(C) Cerebral Emboli  
DUE TO

1 yr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from Oct 1947 to April 1950 that I last saw the deceased alive on April 1950 and that death occurred at 4 PM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 26 1950

Baltimore City Health Department

Henry J. Jenkins, Son Co 4905 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



Dr. Chas F. O'Donnell  
7301 York Rd.



50 3856

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3856

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>John C. Hayes</i>		2. DATE OF DEATH <i>4/23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2415 Lauretta Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission): A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>40</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore Cnd 20-02</i>	
c. Length of stay in Baltimore <i>40</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	

5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Jan 1, 1888</i>	9. AGE (in years, last birthday) <i>62</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Radio repair</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Ireland</i>	
13. FATHER'S NAME <i>John C. Hayes</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Connors</i>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>313-10-0750</i>		17. INFORMANT ADDRESS <i>Libby Annos 2415 Lauretta Ave</i>	

18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arterio-sclerosis C.V.D</i>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *Jan 1945* to *May 23, 1950* that I last saw the deceased alive on *April 23, 1950* and that death occurred at *11:30* p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>J. Permut</i>	23B. ADDRESS <i>3325 Treble Ave</i>	23C. DATE SIGNED <i>4/24/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4/27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cmn</i>
24D. LOCATION (City, town, or county) <i>Edmondson Ave &amp; Fenchfield</i>		24E. STATE <i>MD</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 25 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	25. FUNERAL DIRECTOR ADDRESS <i>Chas P. Towell, 2427 Edmondson Ave</i>

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3325 Franklin Ave  
St. Paul, Minn.

Ed 1047

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3857

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)JOHN GOLEMBIEWSKI2. DATE  
OF  
DEATH4/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. CityB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION1721 Aliceanna St

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. City 2-03

D. STREET ADDRESS (If rural, give location)

1721 Aliceanna St.

c. Length of stay in Baltimore

50Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)WIDOWED

8. DATE OF BIRTH

18829. AGE (in years  
last birthday)67If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)Retired Tailor10B. KIND OF BUSINESS OR  
INDUSTRYTailoring

11. BIRTHPLACE (State or foreign country)

Poland12. CITIZEN OF  
WHAT COUNTRY?U.S.

13. FATHER'S NAME

Golembiewski

14. MOTHER'S MAIDEN NAME

L15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Helen Sokolis 1721 Aliceanna St

18.

444X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Hypertension Vascular18y

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis (General)18y

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

☐

WORK

NOT WHILE

☐

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Mar, 1950 to 25 Apr, 1950, that I last saw the  
deceased alive on 25 Apr, 1950, and that death occurred at 9:45 a m., from the causes and on the date stated above.

23A. SIGNATURE

J. H. Williams

M. D.

23B. ADDRESS

2214 E Fayette St 81

23C. DATE SIGNED

Apr 25 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial4/28/50Holy RosaryBalto. Co.DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 26 1950Thurston Williams, M.D.Wm. S. Zialkowski 2007 Eastern Ave

JOHN VOLUNTARY

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John

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50 3858BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3858  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert Gibson

2. DATE  
OF  
DEATH

4/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1206 W. Lexington St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

18-02

D. STREET ADDRESS (If rural, give location)

1206 W. Lexington St.

c. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

May 12 - 1933

9. AGE (In years last birthday)

16

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

John Gibson

14. MOTHER'S MAIDEN NAME

Rachel E. Rusch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

John Gibson - 1106 W. Lexington St

18. 002X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Pulmonary tuberculosis

Not known

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER- LYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-15, 1950, to 4-25, 1950, that I last saw the deceased alive on 4-22, 1950, and that death occurred at 4:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

C. R. Campbell

23B. ADDRESS

718 Dolphin St

23C. DATE SIGNED

4-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

B.

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

Western Star

24D. LOCATION (City, town, or county)

Catonville

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Samuel W. Sullivan, Jr.

1011 N. Arlington Ave L3B

APR 26 1950

3-10-58

MEMORANDUM

TO :

FROM :

SUBJECT :

RE :

DATE :

BY :

FOR :

FILE :

NOTES :

REFERENCE :

ATTENTION :

REMARKS :

APPROVAL :

SIGNATURE :

DATE :



F-652

JL-137002

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3859

Registered No.

BIRTH NO. 50 3859

1. NAME OF DECEASED (Type or Print) <b>Martin Frances</b>			2. DATE OF DEATH <b>4-18-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>10-02</b>		
c. Length of stay in Baltimore <b>20 yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>1100 E. Monument St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Feb. 16, 1887</b>	9. AGE (In years last birthday) <b>63</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>STONE QUARRY</b>		
11. BIRTHPLACE (State or foreign country) <b>N. Y. N. Y.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Thomas Fraces</b>			14. MOTHER'S MAIDEN NAME <b>Martha</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave</b>			ADDRESS		

MEDICAL CERTIFICATION	18. <b>582 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Liver Abscess.</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Inflamitroy Disease. of Rectum.</b> DUE TO		
	(C)		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>April 5, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Drainage of liver Abscess</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office hldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-2-50</b> , 19 <b>50</b> , to <b>April 18</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>April 18</b> , 19 <b>50</b> , and that death occurred at <b>5.30pm</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b> M. D.		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>April, 22-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 26, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>		25. FUNERAL DIRECTOR <b>Joseph L. Russ</b> ADDRESS <b>1200 McCulloh St., Balt., Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 26 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		125 B	

988 VB

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DETAILED STATEMENT OF CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DIVORCE

DATE OF RE-MARRIAGE

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

R-560

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3860  
Registered No.

BIRTH NO. 50 3860

1. NAME OF DECEASED  
(Type or Print)

LOUIS REAMER

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)US Marine Hospital  
Wyman Pk. Drive & 31st St.C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

c. Length of stay in Baltimore

?

D. STREET ADDRESS (If rural, give location)

1009 W. North Avenue

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

1/26/06

9. AGE (In years  
last birthday)

44

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Messman

10B. KIND OF BUSINESS OR  
INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Isaac Reamer

14. MOTHER'S MAIDEN NAME

Bessie Isaacs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Army-WW2

16. SOCIAL  
SECURITY NO.

212-28-6084

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Bal to, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Hemorrhage due to rupture of  
esophageal varix due to cirrhosis  
of liver

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 25, 1950, to Apr. 25, 1950, that I last saw the  
deceased alive on Apr. 25, 1950, and that death occurred at 8:45P. m., from the causes and on the date stated above.23A. SIGNATURE  
Stuart M. Sessions, SA Surgeon

23B. ADDRESS

23C. DATE SIGNED

US Marine Hospital, Balto, Md. 4/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Herring Run Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 26 1950

Huntington Williams, M.D.

Sol Lewin &amp; Ben W North ave

STATE OF TEXAS  
COUNTY OF DALLAS

WITNESSES

DEED

FOR THE YEAR 1900

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3861

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

ALEKSANDRA JASTRZEMSKA

2. DATE

OF DEATH April 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION 429 S. Durham Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

429 S. Durham Street

c. Length of stay in Baltimore 30 yrs

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

January 1, 1893

9. AGE (In years,  
last birthday)

57

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Kazimierz Litwinski

14. MOTHER'S MAIDEN NAME

Albina Marcik

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Felix Jastrzemski, 429 S. Durham Street

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis  
Chr. MyocarditisApril 22, 50  
Jan 1, 1949

## ANTECEDENT CAUSES

(B) DUE TO

Generalized Arterio-Sclerosis

Jan 1, 1948

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 1, 1949, to April 23, 1950, that I last saw the deceased alive on April 23, 1950, and that death occurred at 9:25 p. m., from the causes and on the date stated above.

23. SIGNATURE

William J. Rybanski

M. D.

23B. ADDRESS

801 W. Kenwood Ave

23C. DATE SIGNED

April 24, 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

M. F. Sadowski, Son, 1808 Eastern Avenue

ADDRESS

APR 26 1950

93D



STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Sex		Race	
Marital Status		Cause of Death	
Occupation		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Death	



5-2003862

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3862  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARJIA

SAUKA SAUKA

2. DATE  
OF DEATH April 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

612 W. Baltimore Street

c. Length of stay in Baltimore

6 wks.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

JUNE - 1876

9. AGE (in years last birthday)

74

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

Lithuania

13. FATHER'S NAME

JOUZAS SAUKA

14. MOTHER'S MAIDEN NAME

MARJIA GERULIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

ADDRESS

ANELI GELGUDA 612 W. BALTO. ST.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 4/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

APR 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Charles W. Schaefer 703 McKeighly St.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

THE COUNTY OF ...

STATE OF ...

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T-643  
MS--117427

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3863  
Registered No.

BIRTH NO. 50 3863		2. DATE OF DEATH 4-25-50	
1. NAME OF DECEASED (Type or Print) Alfred Tarleton		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTE location) Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-03	
c. Length of stay in Baltimore 50 yrs.		D. STREET ADDRESS (If rural, give location) 2319 Ashland Ave.	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec. 19, 1872
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
13. FATHER'S NAME Robert Henry		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Zipporrah Hewitt	
17. INFORMANT ADDRESS Baltimore City Hospitals Records* 4940 Eastern Ave.		18. 331X I	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST,		(A) Cerebro-vascular accident	
		DUE TO	
		(B) Hypertension and arteriosclerosis	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY	
19A. DATE OF OPERATION 2-18-48		19B. MAJOR FINDINGS OF OPERATION Fracture of right hip	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Walk at Patterson Park	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 2-13-1948 11 Am.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from 2-13-1948, to 4-25-1950, that I last saw the deceased alive on 4-25-1950, and that death occurred at 5:55 P.M., from the causes and on the date stated above.		21F. HOW DID INJURY OCCUR? Slipped on the ice and fell to walk	
23A. SIGNATURE [Signature]		23B. ADDRESS 4940 Eastern Ave.	
23C. DATE SIGNED 4-25-50		24. NAME OF CEMETERY OR CREMATORY Mountain View Emmitsburg, Md	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/50	
24C. LOCATION (City, town, or county) (State) Emmitsburg, Md		25. FUNERAL DIRECTOR [Signature]	
DATE RECEIVED BY LOCAL REGISTRAR APR 25 1950		REGISTRAR'S SIGNATURE [Signature]	
VS 150		83a	

WILLIAM

COOPER

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K-613

50 3864

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3864  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LILLIAN C. KRAFT

2. DATE  
OF  
DEATH

Apr. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

00 3039 Spaulding Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3039 Spaulding Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 6, 1879

9. AGE (In years  
last birthday)

71

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George Coarts

14. MOTHER'S MAIDEN NAME

Sarah Parry

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

George E. Kraft, 3039 Spaulding Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1948 to April 25, 1950, that I last saw the  
deceased alive on April 23, 1950, and that death occurred at 11:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

John P. Glueck

M. D.

23B. ADDRESS

5356 Reservoir

23C. DATE SIGNED

4/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

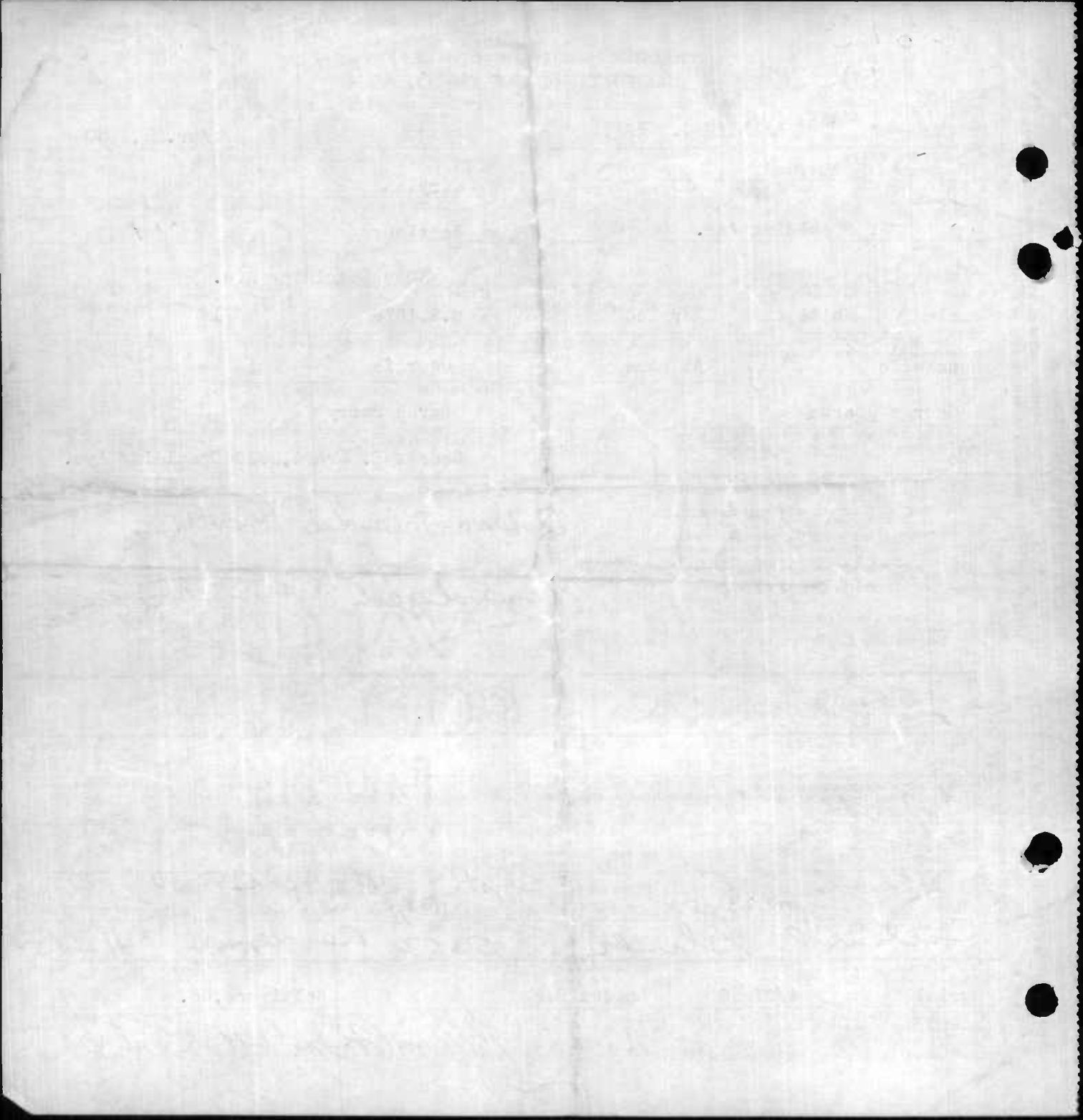
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

William C. Ford 1217 St Paul St





E-524

50

3865

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

3865

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARENCE W. ENGLER

2. DATE  
OF  
DEATH

April 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore 20-03

D. STREET ADDRESS (If rural, give location)

217 S. Eulachin St.

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

217 S. Eulachin St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

June 5, 1878

9. AGE (In years,  
last birthday)

71

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Caretaker - Ref.

10B. KIND OF BUSINESS OR  
INDUSTRY

Contracting

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

Katie Sellers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Rosa Engle - 46 S. Roswell St.

18.

443X I

CAUSE OF DEATH

Chronic Myocarditis and  
Myocardial DegenerationINTERVAL BETWEEN  
ONSET AND DEATH

years

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertensive Cardio-  
Vascular Disease

years

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema

years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT

NOT WHILE

WORK

AT WORK

22. I hereby certify that I attended the deceased from February 14, 1950, to April 23, 1950, that I last saw the  
deceased alive on April 22, 1950, and that death occurred at 8:40 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Melvin H. Bradley

M. D.

23B. ADDRESS

2030 W. Fayette St

23C. DATE SIGNED

4/25/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

4-27-50

Cathedral

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Antington Williams, M.D.

George A. Foley, Funeral Home, Fayette St

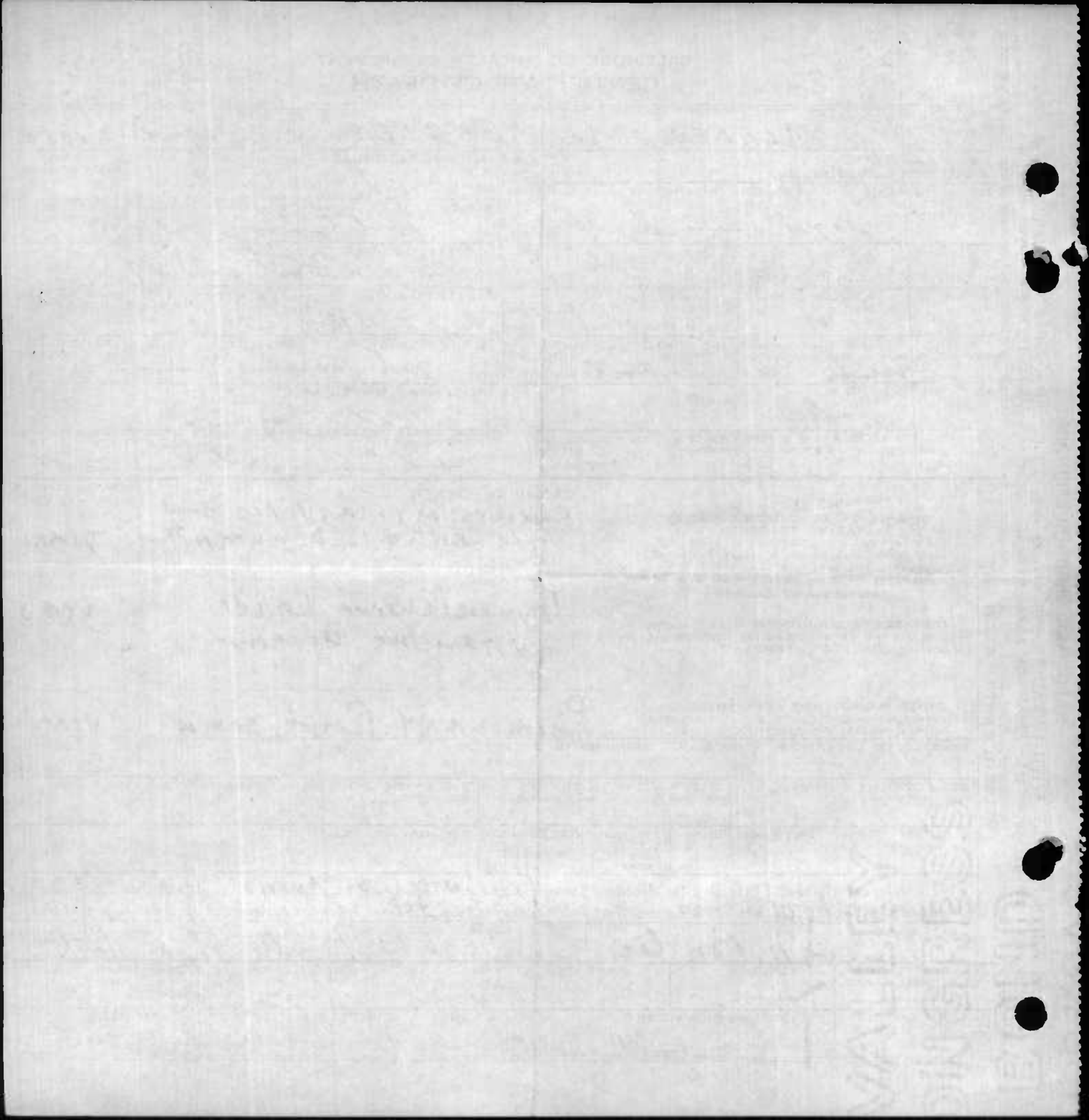
APR 26 1950

308V9

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be carefully studied. The  
cause of death is especially important. Physicians: please write the causes of death clearly and legibly.



F-435  
30 3866BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3866

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Alfred Fulton

2. DATE  
OF  
DEATH

APR 26 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give kind of  
HOSPITAL OR location)  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 18-02

D. STREET ADDRESS (If rural, give location)

7th Carrollton Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

10-25-88

9. AGE (In years  
last birthday)

61

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

carpenter

10B. KIND OF BUSINESS OR  
INDUSTRY

unemployed

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

unknown Fulton

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

403-12-6447

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 541.0

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) gastro intestinal hemorrhage  
DUE TO due to duodenal ulcer

1 week

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)   
DUE TO   
(C)   
II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONOITION CAUSING IT.

Aortic insufficiency due to syphilis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-17-50 to 4-26-50, that I last saw the  
deceased alive on 4-26-50 and that death occurred at 6:40 m., from the causes and on the date stated above.

23A. SIGNATURE

E. J. H. Schoenrich

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

removal

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Memphis

24D. LOCATION (City, town, or county)

Memphis, Tennessee

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christington Williams, M.D.

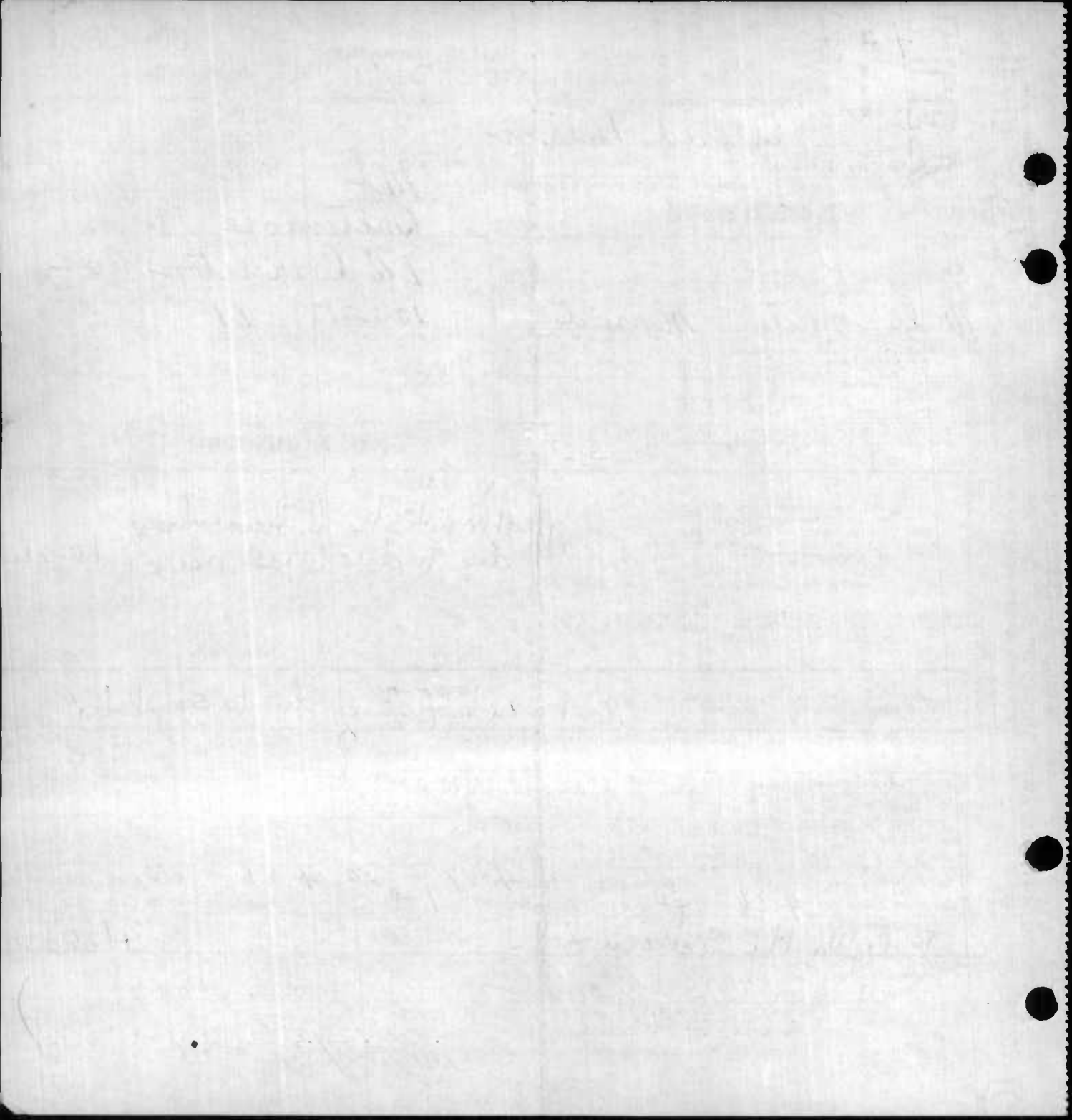
25. FUNERAL DIRECTOR

Wm. Cook, Jr., 217 Paul Street

APR 26 1950

304UG

30E



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-524

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3867

Registered No.

BIRTH NO. <u>50 3867</u>		2. DATE OF DEATH <u>4/24/50</u>	
1. NAME OF DECEASED (Type or Print) <u>Robert Hemsley</u>		3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>521 - Moore St. Life</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Cecil</u> C. CITY OR TOWN (If outside corporate limits write RURAL and give township) <u>Baltimore 17-01</u> D. STREET ADDRESS (If rural, give location) <u>521 - Moore Street</u>	
c. Length of stay in Baltimore		8. DATE OF BIRTH <u>Jan. 7, 1890</u> 60	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	9. AGE (in years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Warehouse</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no.</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS <u>Clara Easton - Wash. D.C.</u>	
18. <u>455X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Stagnation of legs hypertension</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Feb 15</u> , 19 <u>50</u> , to <u>April 24</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>50</u> , and that death occurred at <u>11 A</u> m., from the causes and on the date stated above.	
23A. SIGNATURE <u>J. B. Stewart</u>		23B. ADDRESS <u>632 Franklin St</u>	
23C. DATE SIGNED <u>April 25</u>		24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24B. DATE <u>4/29/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
24D. LOCATION (City, town, or county) <u>Cedar Hill Md</u>		24E. LOCATION (State) <u>Md</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 26 1950</u>		REGISTRAR'S SIGNATURE <u>Thurston Williams</u>	
FUNERAL DIRECTOR <u>W. Halstead</u>		ADDRESS <u>918 - 98852</u>	





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3868  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Willie Belle Jackson

2. DATE  
OF  
DEATH

April 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 340 Bloom St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore,

14-03

C. Length of stay in Baltimore

41 yrs.

Yrs.  
Mos.  
Days

O. STREET ADDRESS (If rural, give location)

340 Bloom St.

5. SEX

Female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Jan. 17, 1871

9. AGE (In years last birthday)

79

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Haywood Madison Co. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Jackson

14. MOTHER'S MAIDEN NAME

Rebecca Marcus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Miss. Martha Jackson 340 Bloom St.

18. 420.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic  
Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1949, to April 26, 1950, that I last saw the deceased alive on April 26, 1950, and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Stanford P. Messenger

M. O.

23B. ADDRESS

2309 Duval Hill

23C. DATE SIGNED

4-26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

April 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

Family Burial ground

24D. LOCATION (City, town, or county)

Haywood-Madison Co. Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons 1900 Eutaw Place

APR 26 1950

93D

CERTIFICATE OF DEATH

Willie Pearl Jackson

10/10/1907

11 yrs.

single

married

Willie Jackson

10/10/1907

10/10/1907

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3869

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)*Lillie May Neary*2. DATE  
OF  
DEATH*25 April 50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION*Good Samaritan Home  
27 W. Carey St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*MD.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Balto. 10-01*

D. STREET ADDRESS (If rural, give location)

*1031 Valley St.*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Widowed*

8. DATE OF BIRTH

*12/31/1876*9. AGE (In years  
last birthday)*73*If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Housewife*10B. KIND OF BUSINESS OR  
INDUSTRY*At Home*

11. BIRTHPLACE (State or foreign country)

*Balto. Md.*12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

*Ephraim Little*

14. MOTHER'S MAIDEN NAME

*Jane Keller*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*No*16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

*Elizabeth Gorman 1627 Euter Place*18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) *Coronary Thrombosis*

DUE TO

*Hypertensive and*

(B)

*Arteriosclerotic cardio-vascular*

DUE TO

*diuresis*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.*Asthma, bronchial*

19A. DATE OF OPERATION

*0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *22 Mar*, 19*50*, to *25 April*, 19*50*, that I last saw the  
deceased alive on *24 April*, 19*50*, and that death occurred at *12:30 A.* from the causes and on the date stated above.

23A. SIGNATURE

*Emil H. Henning Jr.*

M. D.

23B. ADDRESS

*601 Winans Way*

23C. DATE SIGNED

*25 April 50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*4/28/50*

24C. NAME OF CEMETERY OR CREMATORY

*Moreland Park*

24D. LOCATION (City, town, or county)

*Parkville Md.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR*APR 27 1950*

REGISTRAR'S SIGNATURE

*Wm. C. Cook, Inc.*

25. FUNERAL DIRECTOR

ADDRESS

*Wm. C. Cook, Inc. 1217 St. Paul St*

CERTIFICATE OF DEATH

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

50 3870

Registered No.

BIRTH NO. 3870

1. NAME OF DECEASED  
(Type or Print)

HARVEY

LEE

2. DATE  
OF  
DEATH

April 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2646 Huntington Avenue

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 4, 1867

9. AGE (In years  
last birthday)

-83 82

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR  
INDUSTRY

Gen. repairs to house

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Raymond H. Lee, 2227 Penrose Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

QUE TO

ANTECEDENT CAUSES

(B)

QUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Huntington Ave. 55' N. of 27th St. 12/7

21D. TIME (Month) (Day) (Year) (Hour)

4/25/50 7:55 P. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hit by car while crossing Huntington Ave.

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*Carl R. Royce*

23B. CHIEF MEDICAL EXAMINER.....

M.D.

23C. DATE SIGNED

23D. ASSISTANT MEDICAL EXAMINER.....

26 April 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/28/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 27 1950

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

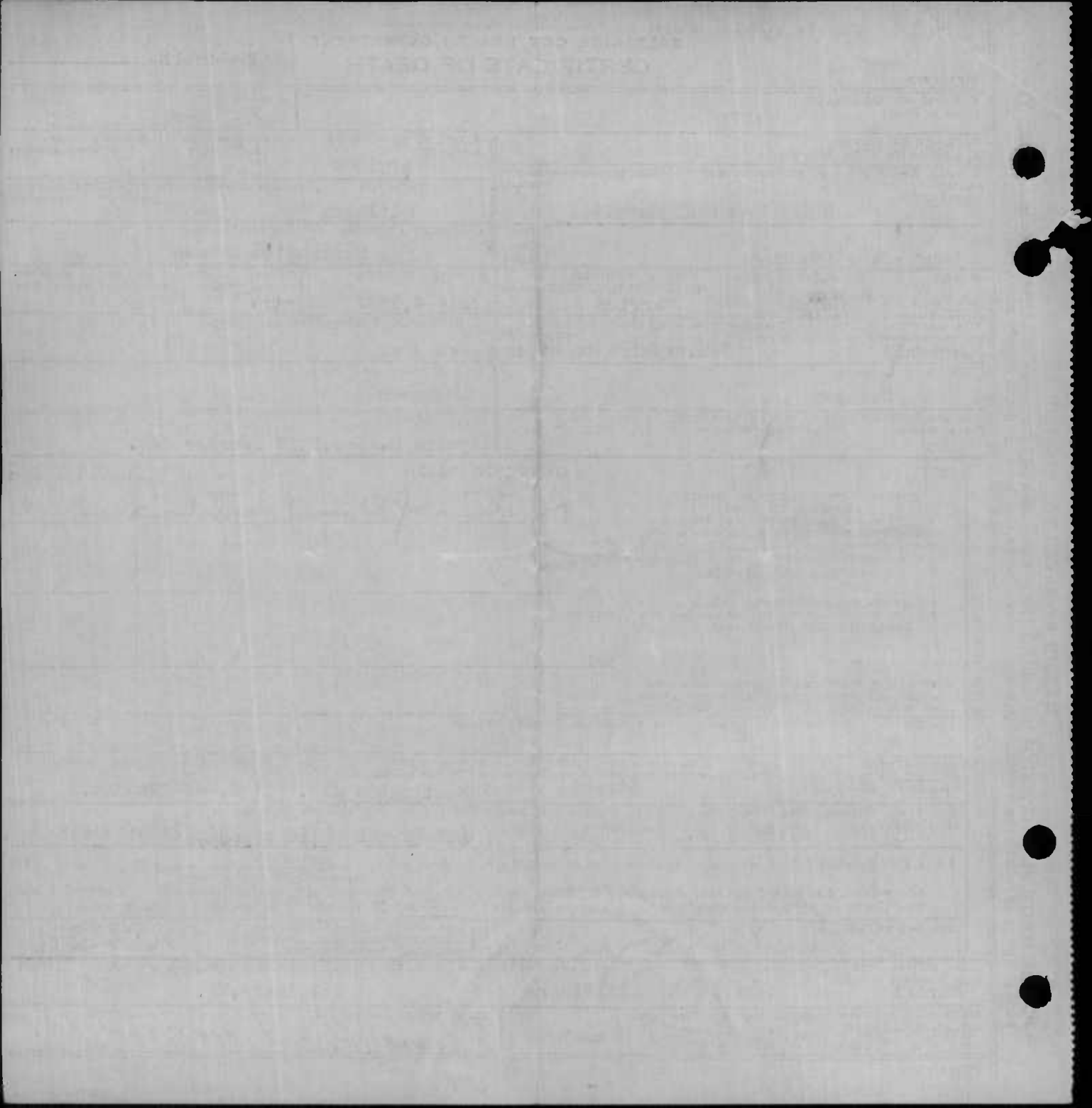
25. FUNERAL DIRECTOR

*William C. ... 1214 St. Paul St.*

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





B-626

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3871

50 3871  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

Frances Brooker

2. DATE  
OF  
DEATH

Apr. 26, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington

D. STREET ADDRESS (If rural, give location)

411 T St N.W.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

12-7-08

9. AGE (In years last birthday)

41

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Blanche Peachy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 163 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cardiac arrest

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma, right lung

DUE TO

(C)

1 yr.

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4/25/50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma, rt. lung

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐NOT WHILE ☐

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/18, 1950, to 4/26, 1950, that I last saw the deceased alive on 4/26, 1950, and that death occurred at 10:55 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Richard X. Kupper, M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/26/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

4/26/50

24C. NAME OF CEMETERY OR CREMATORY

Washington, D.C.

24D. LOCATION (City, town, or county)

Washington, D.C.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

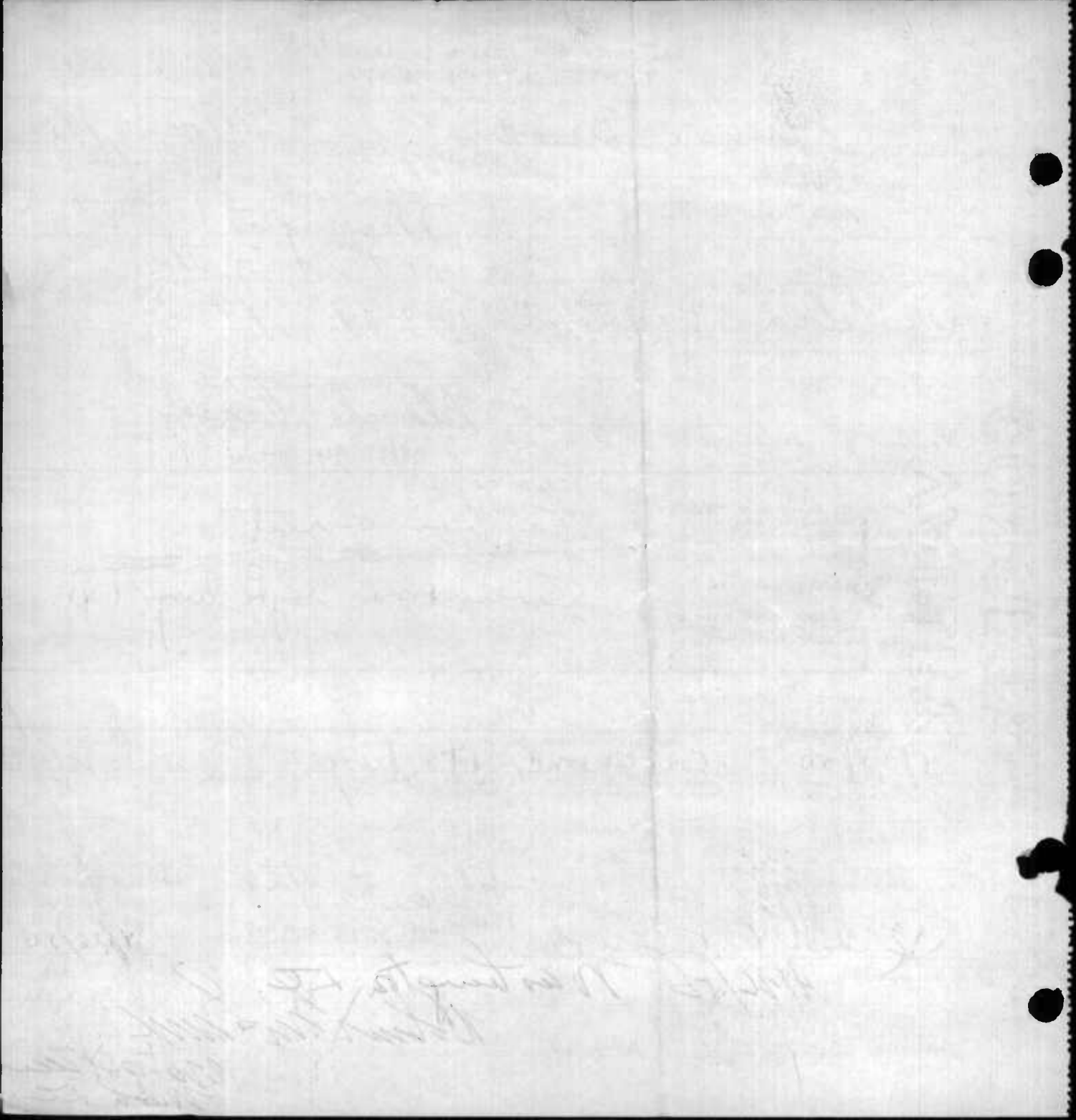
25. FUNERAL DIRECTOR

Robert M. Smith

ADDRESS

VS 150

4771870-987  
Wash. D.C.MARGIN RESERVED FOR BINDING  
PLEASE WRITE MAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3872

BIRTH NO. 625 3872

1. NAME OF DECEASED  
(Type or Print) CATHERINE GARRISON2. DATE  
OF DEATH April 25, 19503. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY BaltimoreB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Loreley 5300

Johns Hopkins Hospital

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Aug. 29, 1949

9. AGE (In years last birthday)

If Under 1 Year  
Months: Days

7 8 27

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Loreley, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

Briley Oswald Garrison

14. MOTHER'S MAIDEN NAME

Catherine Anita Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Catherine A. Garrison Loreley, Md.

18. 370.3

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Purulent meningitis  
~~Septicemia~~ (Bacterial agent not isolated)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
m. WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
M.D. MEDICAL INVESTIGATOR ☐23C. DATE SIGNED  
April 26, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/28/50

24C. NAME OF CEMETERY OR CREMATORY

John Westley Cemetery

24D. LOCATION (City, town, or county)

Magnolia, Maryland

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Fisher &amp; Bell

ADDRESS

556 Lewis Street  
Havre de Grace, Md.

26071-05

1.0.23.11

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3873

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)*Charles A. Schaub (Schaub)*2. DATE  
OF  
DEATH*4/26/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*34 Bon Secours Hospital*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore**20-04*

c. Length of stay in Baltimore

*Life*

D. STREET ADDRESS (If rural, give location)

*6 S. Pulaski St.*

5. SEX

*Male*

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*9/27/70*

9. AGE (In years last birthday)

*79*If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Clerk*

10B. KIND OF BUSINESS OR INDUSTRY

*B & O R R*

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

*U.S.C.*

13. FATHER'S NAME

*John M. Schaub*

14. MOTHER'S MAIDEN NAME

*Catherine Higgins*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

*-*

17. INFORMANT

*Alice T. Schaub*

ADDRESS

*6 S. Pulaski St.*18. *4/20.0*

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Arteriosclerotic Heart Disease*

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Dissective Basal Ganglia Hypertrophy  
Base low grade Intestinal obstruction*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4/3*, 19*50*, to *4/26*, 19*50*, that I last saw the deceased alive on *4/20*, 19*50*, and that death occurred at *2:45* m., from the causes and on the date stated above.

23A. SIGNATURE

*Frank A. Laramie*

M. D.

23B. ADDRESS

*Bon Secours Hospital*

23C. DATE SIGNED

*4/26/50*24A. BURIAL, CREMATION,  
REMOVAL (Specify)*Burial*

24B. DATE

*4/29/50*

24C. NAME OF CEMETERY OR CREMATORY

*New Cathedral Cem.*

24D. LOCATION (City, town, or county) (State)

*4300 Old Frederick Rd.*

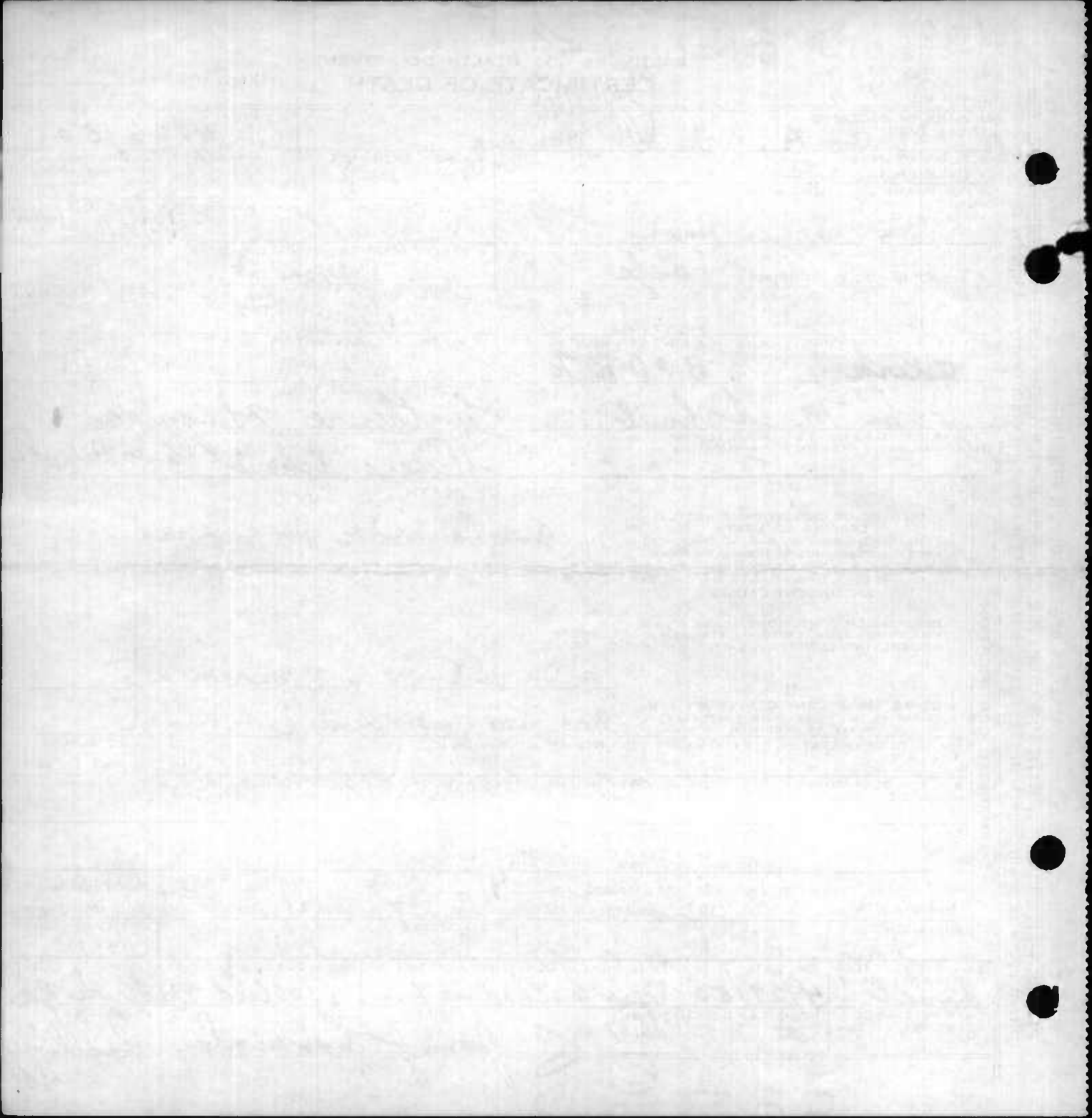
DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*APR 27 1950**William M. Williams, M.D.**John J. Cowan & Son**Hollins*





MARGIN RESERVED FOR BINDING

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-560  
50 3874  
JEANNOT

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3874  
Registered No.

1. NAME OF DECEASED (Type in Print) <b>JEANNOT (JAMES) WEINER</b>		2. DATE OF DEATH <b>25 APRIL 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b> <b>13-04</b>	
C. Length of stay in Baltimore <b>45</b> Yrs. <b>Mon.</b> <b>Days</b>		D. STREET ADDRESS (If rural, give location) <b>2313 AVALON AVE.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>APRIL 30, 1881</b>
9. AGE (In years last birthday) <b>70</b>		10. Under 1 Year Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country) <b>EUROPE. Latvia</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>ROSEN WEINER</b>		14. MOTHER'S MAIDEN NAME <b>HELEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Beccie Weiner</b>		ADDRESS <b>2313 Avalon Ave</b>	
18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> DUE TO ANTECEDENT CAUSES <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>24 APRIL 1950</b> to <b>25 APRIL 1950</b> , that I last saw the deceased alive on <b>25 April, 1950</b> , and that death occurred at <b>12:00 P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Sten W. Demand</b>		23B. ADDRESS <b>FRANKLIN SQ. HOSP BALTI. MD.</b>	
23C. DATE SIGNED <b>25 April 1950</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <b>4-27-50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Sherrin Tfoloh</b>		24D. LOCATION (City, town, or county) (State) <b>Balti Md.</b>	
25. FUNERAL DIRECTOR <b>Jack Lewis</b>		ADDRESS <b>2100 Eutaw Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>4/26/50</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, Jr.</b>	

34069

937

THE JOURNAL OF THE  
CENTRAL BANK OF INDIA

(T.M.V.191)

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3875BIRTH NO. 50 3875

1. NAME OF DECEASED (Type or Print) <b>George F. Sauerwald</b>			2. DATE OF DEATH <b>4/25/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>538 N. Payson St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>538 N. Payson St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8/12/1871</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT ADDRESS <b>LeRoy M. Sauerwald 538 N Payson St.</b>		

18. <b>4/20.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Coronary Occlusion</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>4/25/50</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Arterio sclerosis cardio-vascular disease.</b> DUE TO			<b>?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C) Prostatic Hypertrophy</b>			<b>?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1/28</b> , 19 <b>49</b> , to <b>4/21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/21</b> , 19 <b>50</b> , and that death occurred at <b>8:30 P. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Carl Probst</b>		23B. ADDRESS M. D. <b>1326 W. Lombard St.</b>		23C. DATE SIGNED <b>4-27-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/28/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn Balto, Co. Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>J.T. Stansbury 2700 Edmondson Av.</b>			

1826 W. Longwood 9-17

R-163

50 3876

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3876

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN D. ROBERTSON

2. DATE  
OF  
DEATH APRIL 26 1950

3. PLACE OF DEATH:

A. Baltimore, City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

5501 WOODCREST AVE.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

W

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

DEC. 18 1866

9. AGE (In years;  
last birthday) Months: Days Hours: Min.

83

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

STATIONARY ENGINEER

10B. KIND OF BUSINESS OR  
INDUSTRY

RETIRED U.S. GOVT.

11. BIRTHPLACE (State or foreign country)

OCEAN MD.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

DAVID ROBERTSON

14. MOTHER'S MAIDEN NAME

VICTORIA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MR. HELEN B ROBERTSON 5501 WOODCREST AVE.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Cardio Vascular  
Disease

6 mo's

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from Apr 1 1950, to Apr 26, 1950, that I last saw the  
deceased alive on Apr 25, 1950, and that death occurred at 6:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

William F. Frey

M. D.

23B. ADDRESS

1928 Penna Ave

23C. DATE SIGNED

4/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Fountain Green Pk. Cem.

24D. LOCATION (City, town, or county)

Cumberland Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

William J. Dickner + Sons No + Pa

APR 27 1950







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3877  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Arthur George Hall

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

St. Joseph's

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2806 Winchester St.

c. Length of stay in Baltimore

35 yrs

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

M.

W.

Married

Oct. 7, 1890

59

12. CITIZEN OF  
WHAT COUNTRY?10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Retired Supt.

Balto. Transit Company Calvert Co. Maryland

13. FATHER'S NAME

Thomas Hall

14. MOTHER'S MAIDEN NAME

Rebecca Hutchins

ADDRESS

St.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.  
214-03-7820

17. INFORMANT

Mrs. Elizabeth J. Hall - 2806 Winchester

18.

191X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Metastatic Carcinoma  
(? of Carcinoma of Perineum)

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 11, 1950 to April 25, 1950, that I last saw the  
deceased alive on April 25, 1950, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

S. K. Haas

M. D.

23B. ADDRESS

1100 N. Caroline St.

23C. DATE SIGNED

April 25, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

Christ Epis. Cem.

24D. LOCATION (City, town, or county)

Mutual, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Chas. J. Ichniowski Sons

ADDRESS

Baltimore Md.

APR 27 1950

VS 150

156 49

53

93-10000

10000

10000

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10000

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10000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3878  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Amelia Heying*

2. DATE  
OF  
DEATH

*Apr. 24-1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)  
A. STATE

*MARYLAND*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*BALTIMORE*

*27-02*

*4603 HAMPNETT AVE.*

D. STREET ADDRESS (If rural, give location)

*4603 HAMPNETT AVE.*

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years; last birthday)

10 Under 1 Year Months: Days  
11 Under 24 Hours Hours: Min.

*FEMALE*

*WHITE*

*WIDOWED*

*SEPT. 15-1866*

*83*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

*AT Home*

*HUNGARY*

13. FATHER'S NAME

*KAVATZCHAN*

14. MOTHER'S MAIDEN NAME

*?*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mr. August Heying - 1701 Windermere*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Hypertensive Cardiovascular disease & myocardial decompensation*

*1 year.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Coronary Thrombosis Oct. 1948*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 20 1948* to *April 24, 1950*, that I last saw the deceased alive on *April 22, 1950*, and that death occurred at *9 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Thomas J. Brennan M. D.*

23B. ADDRESS

*5217 Harford Rd*

23C. DATE SIGNED

*4-26-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial*

*4-27-50*

*Holy Cross*

*Brooklyn Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*APR 27 1950*

*Huntington Williams, M.D.*

*L. J. Ruck*

*5305 Harford Rd*

Dr. Brennan

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 3879

BIRTH NO. 325

1. NAME OF DECEASED (Type or Print) <u>Charles Edward Hudson, Sr.</u>		2. DATE OF DEATH <u>April 26, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>5006 Belair Road</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 27-01</u>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>5006 Belair Road</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 23-1870</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>C. D. Kenny</u>	9. AGE (In years last birthday) <u>80</u>
13. FATHER'S NAME <u>Frank Hudson</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Mary McCusker</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Margaret Roos-5006 Belair</u>	
18. <u>422.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardio-vascular Disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	

22. I certify that I took charge of the remains described above, held an Inspe thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Wm. H. Kammner, Jr. M.D. 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ 23C. DATE SIGNED April 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/29/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 27 1950</u>	REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>L. J. Luck 5305 Hartford Rd</u>	

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that \_\_\_\_\_  
of the County of \_\_\_\_\_ State of \_\_\_\_\_  
do hereby certify that \_\_\_\_\_  
is the owner of \_\_\_\_\_  
and that \_\_\_\_\_  
is the owner of \_\_\_\_\_

Witness my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_  
A.D. 19\_\_\_\_  
at \_\_\_\_\_ Texas.

Notary Public in and for the State of Texas.

24



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3880

BIRTH NO.

137523

50-08286

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Parsons- Joyce

2. DATE  
OF  
DEATH

4-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

904 McDonough St.

C. Length of stay in Baltimore

11 hrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 24, 1950

9. AGE (In years;  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Willie Holloway

14. MOTHER'S MAIDEN NAME

Joyce Blondine Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Congenital Atelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Prematurity

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ No ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 2, 1950 to April 24, 1950 that I last saw the deceased alive on April 24, 1950, and that death occurred at 12.15pm from the causes and on the date stated above.

23A. SIGNATURE

*W. Rogers*

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Cremated

24B. DATE

4-26-50

24C. NAME OF CEMETERY OR CREMATORY

B. C. H. Crematory

24D. LOCATION (City, town, or county)

4940 Eastern Ave.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wm. H. Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of religious		26. Signature of social		27. Signature of cultural		28. Signature of political	
29. Signature of economic		30. Signature of environmental		31. Signature of technological		32. Signature of scientific	
33. Signature of artistic		34. Signature of literary		35. Signature of historical		36. Signature of geographical	
37. Signature of biological		38. Signature of chemical		39. Signature of physical		40. Signature of mathematical	
41. Signature of medical		42. Signature of legal		43. Signature of military		44. Signature of naval	
45. Signature of aviation		46. Signature of space		47. Signature of nuclear		48. Signature of atomic	
49. Signature of energy		50. Signature of information		51. Signature of communication		52. Signature of transportation	
53. Signature of infrastructure		54. Signature of public works		55. Signature of urban planning		56. Signature of environmental	
57. Signature of natural resources		58. Signature of agriculture		59. Signature of forestry		60. Signature of fishing	
61. Signature of hunting		62. Signature of gaming		63. Signature of gambling		64. Signature of entertainment	
65. Signature of sports		66. Signature of recreation		67. Signature of tourism		68. Signature of education	
69. Signature of health care		70. Signature of social services		71. Signature of human resources		72. Signature of labor	
73. Signature of industry		74. Signature of commerce		75. Signature of finance		76. Signature of insurance	
77. Signature of real estate		78. Signature of construction		79. Signature of manufacturing		80. Signature of mining	
81. Signature of energy		82. Signature of transportation		83. Signature of communication		84. Signature of information	
85. Signature of technology		86. Signature of science		87. Signature of mathematics		88. Signature of physics	
89. Signature of chemistry		90. Signature of biology		91. Signature of medicine		92. Signature of law	
93. Signature of military		94. Signature of naval		95. Signature of aviation		96. Signature of space	
97. Signature of nuclear		98. Signature of atomic		99. Signature of energy		100. Signature of information	
101. Signature of communication		102. Signature of transportation		103. Signature of infrastructure		104. Signature of public works	
105. Signature of natural resources		106. Signature of agriculture		107. Signature of forestry		108. Signature of fishing	
109. Signature of hunting		110. Signature of gaming		111. Signature of gambling		112. Signature of entertainment	
113. Signature of sports		114. Signature of recreation		115. Signature of tourism		116. Signature of education	
117. Signature of health care		118. Signature of social services		119. Signature of human resources		120. Signature of labor	
121. Signature of industry		122. Signature of commerce		123. Signature of finance		124. Signature of insurance	
125. Signature of real estate		126. Signature of construction		127. Signature of manufacturing		128. Signature of mining	
129. Signature of energy		130. Signature of transportation		131. Signature of communication		132. Signature of information	
133. Signature of technology		134. Signature of science		135. Signature of mathematics		136. Signature of physics	
137. Signature of chemistry		138. Signature of biology		139. Signature of medicine		140. Signature of law	
141. Signature of military		142. Signature of naval		143. Signature of aviation		144. Signature of space	
145. Signature of nuclear		146. Signature of atomic		147. Signature of energy		148. Signature of information	
149. Signature of communication		150. Signature of transportation		151. Signature of infrastructure		152. Signature of public works	
153. Signature of natural resources		154. Signature of agriculture		155. Signature of forestry		156. Signature of fishing	
157. Signature of hunting		158. Signature of gaming		159. Signature of gambling		160. Signature of entertainment	
161. Signature of sports		162. Signature of recreation		163. Signature of tourism		164. Signature of education	
165. Signature of health care		166. Signature of social services		167. Signature of human resources		168. Signature of labor	
169. Signature of industry		170. Signature of commerce		171. Signature of finance		172. Signature of insurance	
173. Signature of real estate		174. Signature of construction		175. Signature of manufacturing		176. Signature of mining	
177. Signature of energy		178. Signature of transportation		179. Signature of communication		180. Signature of information	
181. Signature of technology		182. Signature of science		183. Signature of mathematics		184. Signature of physics	
185. Signature of chemistry		186. Signature of biology		187. Signature of medicine		188. Signature of law	
189. Signature of military		190. Signature of naval		191. Signature of aviation		192. Signature of space	
193. Signature of nuclear		194. Signature of atomic		195. Signature of energy		196. Signature of information	
197. Signature of communication		198. Signature of transportation		199. Signature of infrastructure		200. Signature of public works	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3881

1. NAME OF DECEASED (Type or Print) <u>Mary Panther</u>		2. DATE OF DEATH <u>4/25/50</u>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <u>3906 2nd St, Brooklyn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore MD 25-04</u>	
c. Length of stay in Baltimore Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>		d. STREET ADDRESS (If rural, give location) <u>3906 2nd St, Brooklyn</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>11-20-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>59</u>
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Family - SAME.</u> ADDRESS
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive C. U. Disease</u> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23a. SIGNATURE <u>P. J. [Signature]</u>		23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/> <u>4/25/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		24b. DATE <u>4-29-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		24d. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>ADD 27 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
FUNERAL DIRECTOR <u>James L. [Signature]</u>		ADDRESS <u>130 E. Fort Ave. 93</u>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

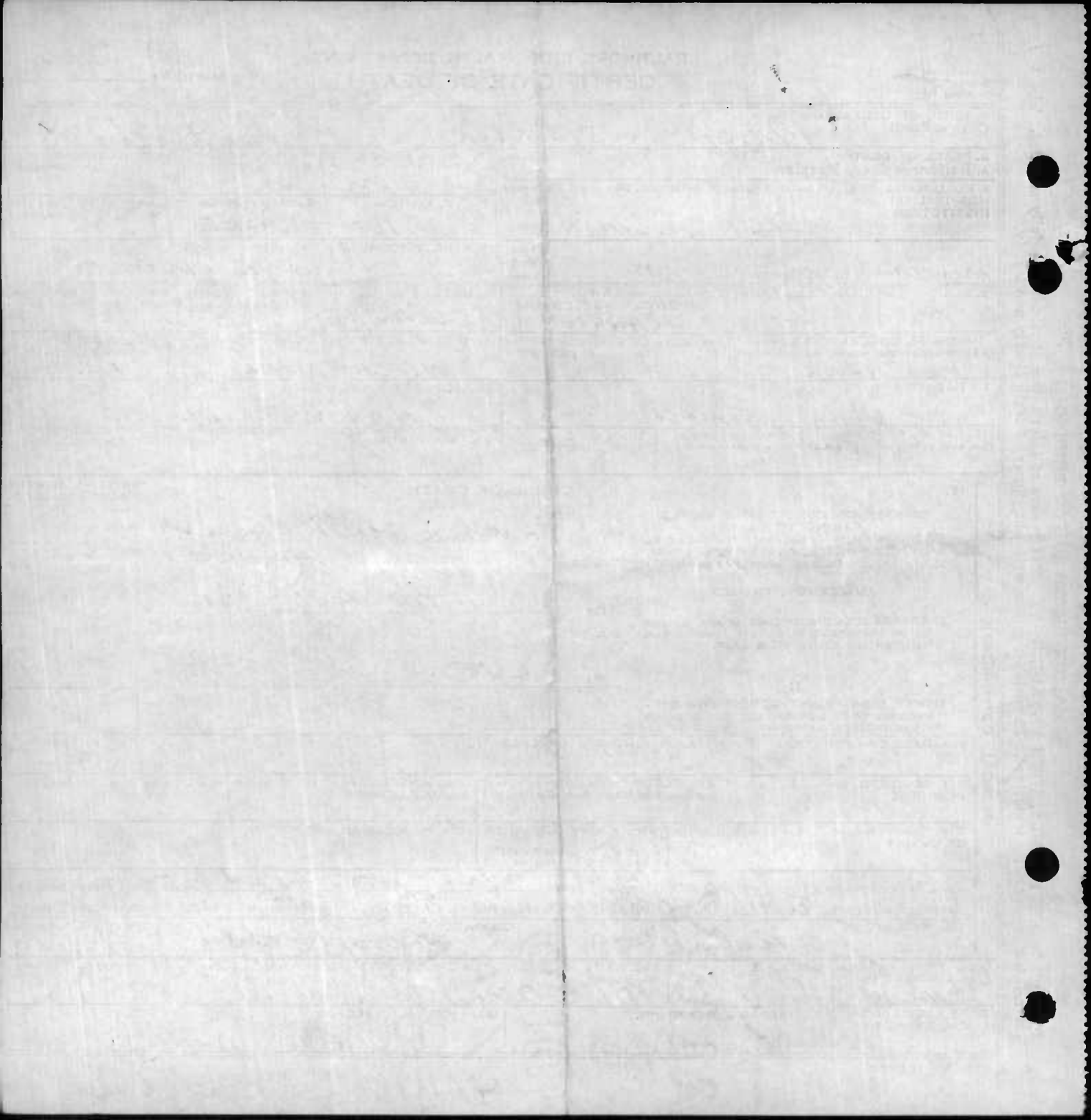
1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of school		18. Signature of hospital		19. Signature of nursing home		20. Signature of other institution	
21. Signature of other institution		22. Signature of other institution		23. Signature of other institution		24. Signature of other institution	
25. Signature of other institution		26. Signature of other institution		27. Signature of other institution		28. Signature of other institution	
29. Signature of other institution		30. Signature of other institution		31. Signature of other institution		32. Signature of other institution	
33. Signature of other institution		34. Signature of other institution		35. Signature of other institution		36. Signature of other institution	
37. Signature of other institution		38. Signature of other institution		39. Signature of other institution		40. Signature of other institution	
41. Signature of other institution		42. Signature of other institution		43. Signature of other institution		44. Signature of other institution	
45. Signature of other institution		46. Signature of other institution		47. Signature of other institution		48. Signature of other institution	
49. Signature of other institution		50. Signature of other institution		51. Signature of other institution		52. Signature of other institution	
53. Signature of other institution		54. Signature of other institution		55. Signature of other institution		56. Signature of other institution	
57. Signature of other institution		58. Signature of other institution		59. Signature of other institution		60. Signature of other institution	
61. Signature of other institution		62. Signature of other institution		63. Signature of other institution		64. Signature of other institution	
65. Signature of other institution		66. Signature of other institution		67. Signature of other institution		68. Signature of other institution	
69. Signature of other institution		70. Signature of other institution		71. Signature of other institution		72. Signature of other institution	
73. Signature of other institution		74. Signature of other institution		75. Signature of other institution		76. Signature of other institution	
77. Signature of other institution		78. Signature of other institution		79. Signature of other institution		80. Signature of other institution	
81. Signature of other institution		82. Signature of other institution		83. Signature of other institution		84. Signature of other institution	
85. Signature of other institution		86. Signature of other institution		87. Signature of other institution		88. Signature of other institution	
89. Signature of other institution		90. Signature of other institution		91. Signature of other institution		92. Signature of other institution	
93. Signature of other institution		94. Signature of other institution		95. Signature of other institution		96. Signature of other institution	
97. Signature of other institution		98. Signature of other institution		99. Signature of other institution		100. Signature of other institution	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3882BIRTH NO. 50 3882

1. NAME OF DECEASED (Type or Print) <u>ROBERT SIMPSON</u>			2. DATE OF DEATH <u>4/29/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE 17-01</u>		
c. Length of stay in Baltimore <u>11</u> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>511 W. BIDDLE ST.</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 26, 1907</u>	9. AGE (In years last birthday) <u>42</u>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Mill.</u>		11. BIRTHPLACE (State or foreign country) <u>N. CAROLINA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>WILL SIMPSON</u>		
14. MOTHER'S MAIDEN NAME <u>NANCY KELLY.</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		

18. <u>073 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>THORACIC AORTIC SACULAR ANEURYSM.</u> DUE TO <u>LUETIC AORTITIS</u> DUE TO <u>LUES.</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/21</u> , 19 <u>50</u> , to <u>4/24</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>50</u> , and that death occurred at <u>8:10</u> Am., from the causes and on the date stated above.					
23A. SIGNATURE <u>La Roberts</u>		23B. ADDRESS <u>Mercy Hospital</u>		23C. DATE SIGNED <u>4/24/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/27/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>My Calvary Cem. A. A. Co.</u>	
24D. LOCATION (City, town, or county) (State) <u>MD</u>		25. FUNERAL DIRECTOR <u>Rayner Sanders</u>		ADDRESS <u>309</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 27 1950</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams</u>		ADDRESS <u>98829/412 E. Preston St</u>	

VS-150





MARGIN RESERVED FOR BINDING

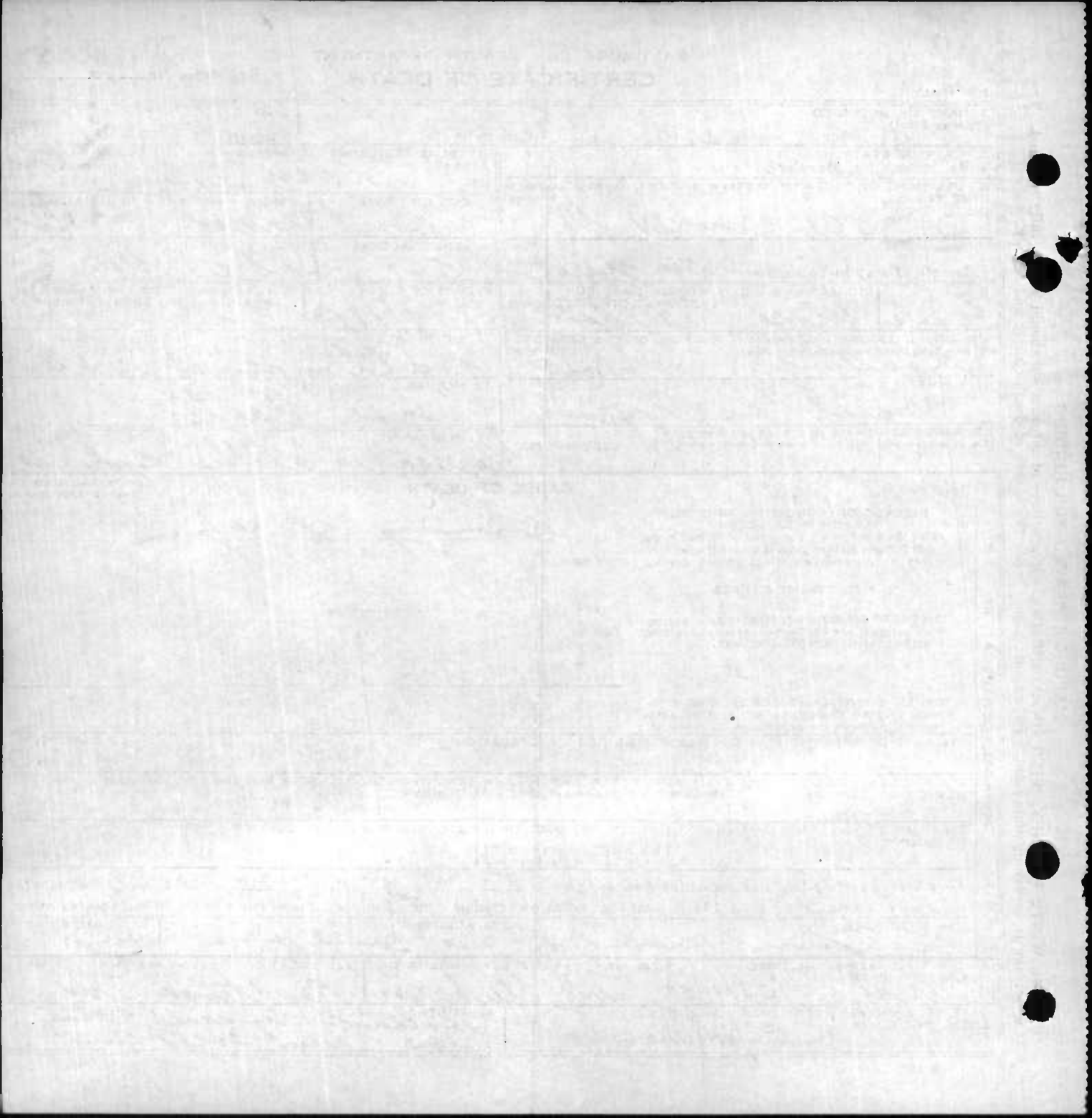
PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-335  
50 3883

STATEN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3883  
Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <i>Mary Staten</i>		2. DATE OF DEATH <i>4/25/1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived: If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>561 Baker St.</i>		C. CITY OR TOWN (If provide corporate limits, write RURAL and give township) <i>Baltimore 14-03</i>			
c. Length of stay in Baltimore <i>56 years</i>		D. STREET ADDRESS (If rural, give location) <i>561 Baker St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>5/27/1883</i>	9. AGE (In years last birthday) <i>36</i>	10. Under 1 Year: Months _____ Days _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Daniel Crispin</i>		14. MOTHER'S MAIDEN NAME <i>Jane Carter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Ms. Sophia Phillips Baker St.</i>	
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Heart Disease</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO _____		(B) DUE TO _____	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-25-1950</i> , to <i>4-26-1950</i> , that I last saw the deceased alive on <i>4-25-1950</i> , and that death occurred at <i>12:30</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Clifford P. Henderson</i>		23B. ADDRESS <i>2309 Druid Hill</i>		23C. DATE SIGNED <i>4-27-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/28/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25. FUNERAL DIRECTOR <i>Shallant Funeral Home</i>		ADDRESS <i>1631 Druid Hill Ave.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 28 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3884

BIRTH NO. 50-10003

1. NAME OF DECEASED (Type or Print) <b>BABY BOY HAMAN</b>			2. DATE OF DEATH <b>April 26, 1950</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>Mercy Hosp</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>13-06</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give township) <b>Baltimore, Maryland</b>		
c. Length of stay in Baltimore <b>2</b> <small>Tues. Mos. Days</small>			d. STREET ADDRESS (If rural, give location) <b>3423 Chestnut Avenue</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>April 24, '50</b>		9. AGE (In years last birthday) <b>2</b> <small>If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.</small>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>J. Vincent HAMAN</b>			14. MOTHER'S MAIDEN NAME <b>Katherine King</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <b>760.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>respiratory failure</b> DUE TO <b>basalar brain hemorrhage</b> <b>prematurity</b> DUE TO <b>prematurity</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 days</b> <b>2 days</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION <b>2</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/24</b> , 19 <b>50</b> , to <b>4/26</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/26</b> , 19 <b>50</b> , and that death occurred at <b>4:30 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>David Joseph</b>		23b. ADDRESS <b>Mercy Hosp</b>		23c. DATE SIGNED <b>4/27/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>April 27, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>	
24d. LOCATION (City, town, or county) (State) <b>Baltimore</b>		25. FUNERAL DIRECTOR <b>Paul E. Chevone</b>		ADDRESS <b>3611 Chestnut</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 27 1950</b>		REGISTRAR'S SIGNATURE <b>James J. Williams, M.D.</b>			

CERTIFICATE OF DEATH

THE DECEASED

WAS

FOUND

DECEASED

ON

THE

DATE

OF

THE

DECEASED

WAS

FOUND

DECEASED

ON

THE

DATE

OF

THE

PLEASE WRITE PROMPTLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# CERTIFICATE CORRECTED 5-1-50

## BALTIMORE CITY HEALTH DEPARTMENT

### CERTIFICATE OF DEATH

50 3885  
Registered No.

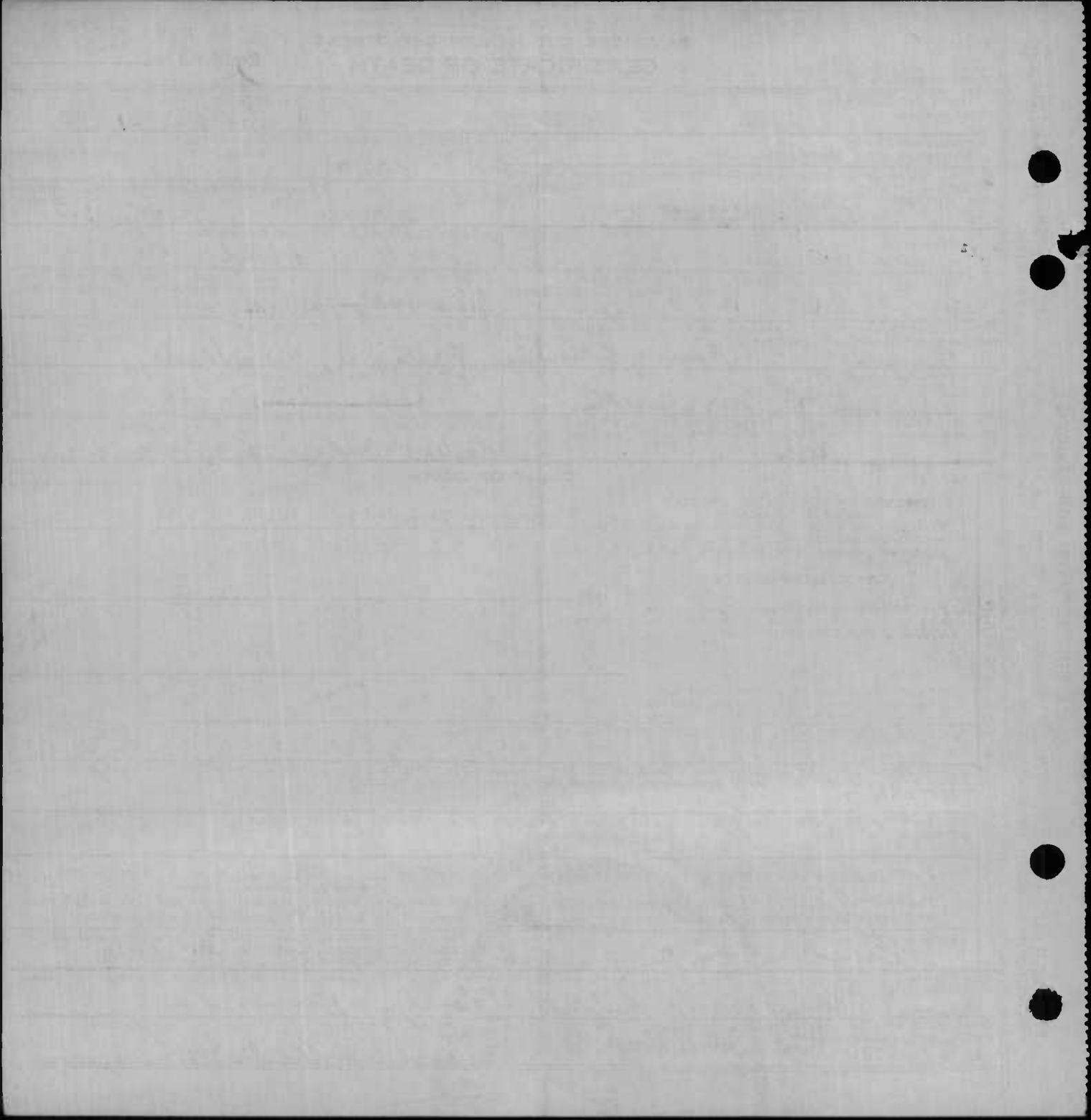
BIRTH NO. 50 3885

1. NAME OF DECEASED (Type or Print) <b>JAMES EDWARD MORGERETH</b>		2. DATE OF DEATH <b>April 26, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3323 E. Baltimore Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-045</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>3514 North Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 14, 1912</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House of collection</b>	
13. FATHER'S NAME <b>Edward B. Morgereth</b>		14. MOTHER'S MAIDEN NAME <b>Ida May Kepper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Saskie V. Morgereth</b>		ADDRESS <b>3514 North St</b>	

18. <b>470.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>[Signature]</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.		23C. DATE SIGNED <b>4/27/50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 29, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Bethesda Hill Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Hanover Street</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 27 1950</b>		25. FUNERAL DIRECTOR <b>Fredrick D. Miller, Inc 30198 Monument St</b>	
REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS	





J-560

50 3886

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3886

Registered No.

BIRTH NO. 4-87162

1. NAME OF DECEASED  
(Type or Print)

Gregory Allen Joyner

2. DATE  
OF  
DEATHApril 26<sup>th</sup> 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1505 Ravencrest Pk.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Life 2 yrs 5 mos 11 days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

Gastric Carcinoma

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

13 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Umbilical Herniectomy March 1949  
at City Hospital

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐22. I hereby certify that I attended the deceased from March 1949, to April 26<sup>th</sup> 1950 that I last saw the  
deceased alive on April 26, 1950 and that death occurred at 12:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

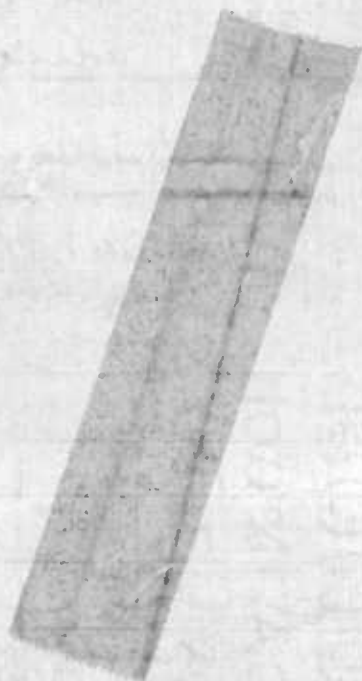
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 27 1950  
VS 150

46B



P-600

50 3887

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3887  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Willie Perry

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Dist 2

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 3-02

D. STREET ADDRESS (If rural, give location)

1116 E. Lombard St.

c. Length of stay in Baltimore

7 years

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3-12-13

9. AGE (In years  
last birthday)

37

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of work life, or retired)

Data B Still G

10B. KIND OF BUSINESS OR  
INDUSTRY

Sp Point

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Horace Perry

14. MOTHER'S MAIDEN NAME

Susie Gantt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMATION ADDRESS

JOHNS HOPKINS HOSPITAL

1B.

467.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Superior Caval Syndrome 4 yrs

DUE TO

ANTECEDENT CAUSES

(B) ? Tuberculous adhesions (over)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-24-1950 to 4-25-1950, that I last saw the  
deceased alive on 4-25-1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

David E. Rogers M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

April 29/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Carey Cmt

24D. LOCATION (City, town, or county)

Crosbyville Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Choy A. Wilson 1000 Brantly Ave

ADDRESS

APR 27 1950

VS 150

9844V

103

See Document File

50 - 3887

"Complete obstruction of  
major vein leading from  
the head neck & upper chest  
into the heart."

So 6.26.50

P-650 PRION 50 3888 BALTIMORE CITY HEALTH DEPARTMENT 50 3888

## CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <i>Mrs. Ellen Prion</i>		2. DATE OF DEATH <i>4/25/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 22 5300</i>			
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home &amp; Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>2998 Sollers Point Road</i>			
c. Length of stay in Baltimore <i>33</i> Yrs. Mos. Days		8. DATE OF BIRTH <i>1/21/1897</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. <del>SINGLE</del> MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	9. AGE (In years last birthday) <i>53</i>	11. BIRTH PLACE (State or foreign country) <i>Pennsylvania</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Daniel Collins</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Murphy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>Miss F. Grabe Church Home &amp; Hosp.</i>	

MEDICAL CERTIFICATION	18. <i>446 X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH (A) <i>Uremia</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>4 wks.</i>
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Arteriosclerotic Nephrosclerosis</i> DUE TO		
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <i>Diabetes Mellitus</i> <i>Cystic Fibrosis of Pancreas</i>		
	19A. DATE OF OPERATION <i>2/</i> 19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>April 17, 1950</i> , to <i>April 25, 1950</i> , that I last saw the deceased alive on <i>April 25, 1950</i> , and that death occurred at <i>2:00 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>James T. Smales</i>		23B. ADDRESS <i>Church Home &amp; Hospital</i>		23C. DATE SIGNED <i>4/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>28 APRIL 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART CEM.</i>	
24D. LOCATION (City, town, or county) (State) <i>OLD GERMAN HILL RD. BALTO.</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 27 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Walter Brooke Bradley, Dundalk, Md.</i>	

61



UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS

WASHINGTON, D.C. 20462

TELEPHONE (202) 401-5000

TELETYPE (202) 401-5000

FACSIMILE (202) 401-5000

MAIL ROOM (202) 401-5000

RECORDS MANAGEMENT (202) 401-5000

GENERAL INVESTIGATIVE DIVISION

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

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GENERAL INVESTIGATIVE DIVISION

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20535

TELEPHONE (202) 401-5000

TELETYPE (202) 401-5000

FACSIMILE (202) 401-5000



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3889

BIRTH NO. 50 3889 50-08486

1. NAME OF DECEASED (Type or Print) <i>Baby Boy Lamb</i>		2. DATE OF DEATH <i>4/25/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Georgia</i> B. COUNTY <i>Plants</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mary Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>Armstead Hotel</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>4/25/50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>John Lamb</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
12. CITIZEN OF WHAT COUNTRY?		14. MOTHER'S MAIDEN NAME <i>Ida Mae Lamb (?)</i>	
17. INFORMANT <i>Mother</i>		ADDRESS	

18. <i>761.5</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Prematurity</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Premature Separation of Placenta</i> DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/25</i> 19 <i>50</i> to <i>4/25</i> 19 <i>50</i> , that I last saw the deceased alive on <i>4/25</i> 19 <i>50</i> , and that death occurred at <i>3:20</i> p. m., from the causes and on the date stated above.			
23A. SIGNATURE <i>Dr. Bone</i>	23B. ADDRESS <i>Mary Hospital</i>	23C. DATE SIGNED <i>4/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4/28/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Bowson, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 27 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>H. W. Mcnairson</i>	ADDRESS <i>805 N. Calvert St</i>

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1012

1012  
1012

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3890BIRTH NO. 50 38901. NAME OF DECEASED  
(Type or Print)Anna M. Werner2. DATE  
OF  
DEATHApril 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore9-06

D. STREET ADDRESS (If rural, give location)

1511 E. 33rd St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)married

8. DATE OF BIRTH

May 7, 18769. AGE (In years  
last birthday)73If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)house wife10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frederick Gross

14. MOTHER'S MAIDEN NAME

Ida L. Bahlke15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Henry F. Werner 1511 E. 33rd St.18. 422.2

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Chronic myocarditis6 mos.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from 12/20, 1950, to 4/24, 1950, that I last saw the  
deceased alive on 4/24, 1950, and that death occurred at 1:50 P. M., from the causes and on the date stated above.

23A. SIGNATURE

J. Willis Guystaw

M. D.

23B. ADDRESS

3961 Greenmount Ave.

23C. DATE SIGNED

4/26/5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)Burial

24B. DATE

4/28/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county)

(State)

7225 Eastern Ave.DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 27 1950Clarence F. HoffmannClarence F. Hoffmann 1639 Broadway.Clarence F. Hoffmann

Mr. Gaylor  
3961 Grinnant ave

Mr. - I'll pick this  
up tomorrow morning.  
Mr. Hoffmann

50 3891

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3891

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Arthur V. Wooldridge

2. DATE  
OF  
DEATH

April 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

B. FULL NAME OF  
(If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3022 Westfield Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-05

D. STREET ADDRESS (If rural, give location)

3022 Westfield Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 16, 1882

9. AGE (In years  
last birthday)

68

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

auditor

10B. KIND OF BUSINESS OR  
INDUSTRY

SELF

11. BIRTHPLACE (State or foreign country)

England

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Charles

14. MOTHER'S MAIDEN NAME

Phoebe Foley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Georgia K. Wooldridge 3022 Westfield Ave

18.

422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Arteriosclerotic cardiovascular disease

?

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Pulmonary Congestion

1 week

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

April 26, 1950 3:04 m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 11, 1950, to April 26, 1950, that I last saw the deceased alive on April 26, 1950, and that death occurred at 3:04 m., from the causes and on the date stated above.

23A. SIGNATURE

J. Salem

23B. ADDRESS

6217 Harford Rd

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Pk.

24D. LOCATION (City, town, or county)

Taylor Ave.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 27 1950

REGISTRAR'S SIGNATURE

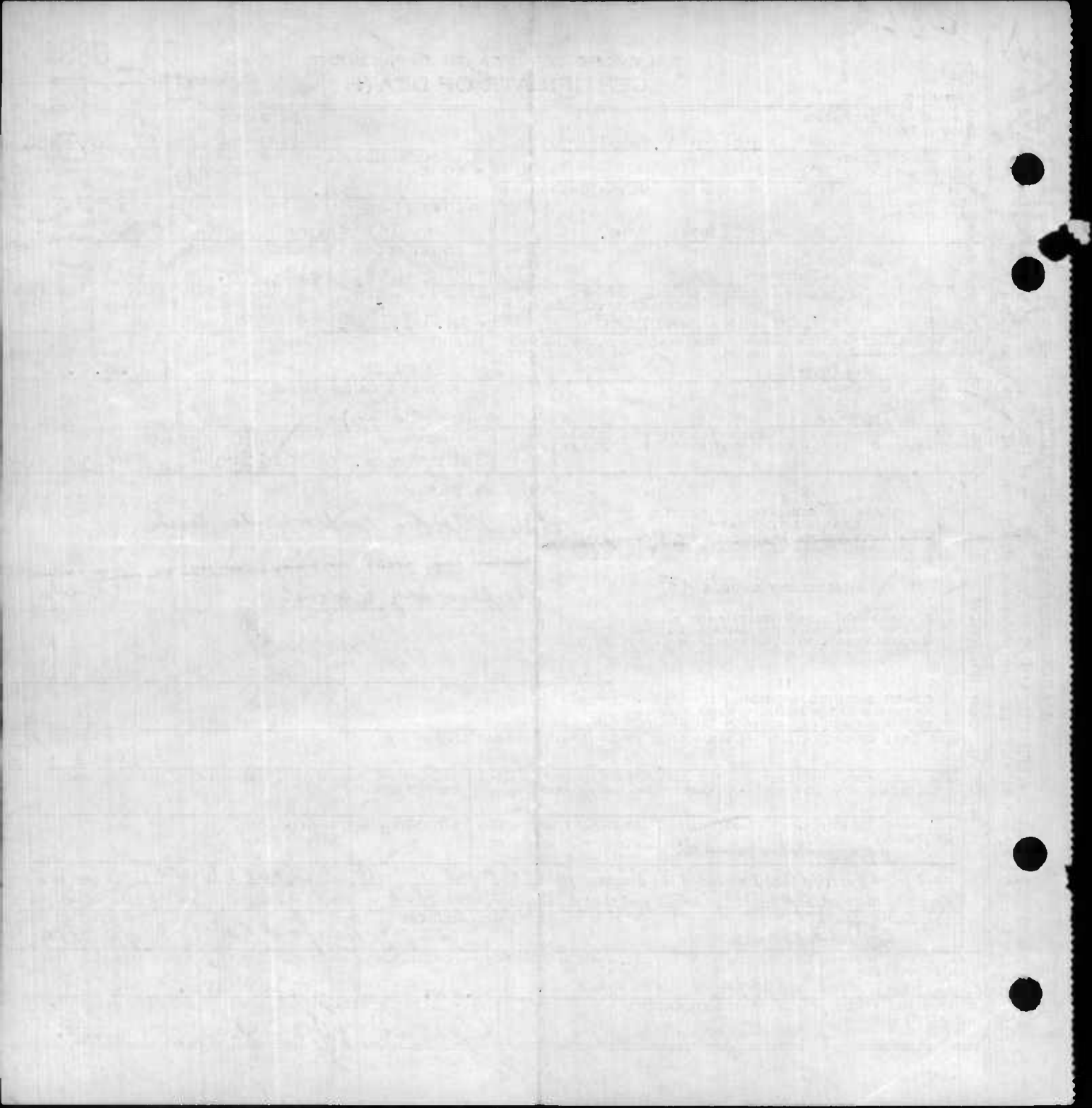
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Blount F. Hoffman

ADDRESS

1639 Broadway.





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

F652 CERTIFICATE CORRECTED 4-27-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3892

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If Yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the  
deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 10:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 27 1950  
VS 150

Huntington Williams, M.D.

E. Astor Sons, Ellicott City

93D MD

CERTIFICATE OF DEATH

103801

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3893  
Registered No. 50 3893

BIRTH NO. 50 3893

1. NAME OF DECEASED (Type or Print) Mary Ann Schmidt			2. DATE OF DEATH April 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-03		
c. Length of stay in Baltimore Unknown Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1911 Fleet St.		
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5/10/1854	9. AGE (In years last birthday) 95	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		(If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Marie Bienleen 6513 Baltimore Ave, Dundalk

18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R.S. Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.		23C. DATE SIGNED April 26, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/29/1950		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
DATE RECEIVED BY LOCAL REGISTRAR APR 27 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25. FUNERAL DIRECTOR Lilly & Zeiler Inc., 403 S. Wolfe St., Balto.		ADDRESS			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
OFFICE OF THE COMMISSIONER  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Blank certificate form with horizontal lines for text entry.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3894

1. NAME OF DECEASED  
(Type or Print)

JACOB BROWN

2. DATE  
OF  
DEATH

April 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE US Marine Hospital

Wyman Pk. Drive &amp; 31st St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Pa.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Philadelphia

D. STREET ADDRESS (If rural, give location)

109 Fairmount Avenue

c. Length of stay in Baltimore

48 days

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1/15/92

9. AGE (In years  
last birthday)

58

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR  
INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Del.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel F. Brown

14. MOTHER'S MAIDEN NAME

Mary L. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

?

16. SOCIAL  
SECURITY NO.

182-18-5913

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18.

162X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of right lung with  
metastases to liver, vertebrae  
and brain

Interval Between  
Onset and Death

Unknown

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)  
DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 7, 1950 to Apr. 27, 1950 that I last saw the  
deceased alive on Apr. 27, 1950 and that death occurred at 12:45 AM, from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

M. D.

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

removal

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Odd Fellows

24D. LOCATION (City, town, or county)

Delaware

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 27 1950

REGISTRAR'S SIGNATURE

H. H. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul Street

CERTIFICATE OF DEATH

1. DECEASED'S NAME

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF MEDICAL OFFICER

12. SIGNATURE OF CLERK

13. SIGNATURE OF CHURCH OFFICER

14. SIGNATURE OF BURIAL OFFICER

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF CEMETERY

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

5/12/1



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE L. TRUMBO

2. DATE  
OF  
DEATH

4/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

338 East 22nd Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

338 E. 22nd Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1876

9. AGE (in years  
last birthday)

74

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY

Race Tracks

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Geo. W. Trumbo

14. MOTHER'S MAIDEN NAME

Margaret L. Trumbo

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.17. INFORMANT  
ADDRESS  
Mrs. Elmer Kraus 338 E. 22nd St.

18. 4721

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1945, to April 24, 1950, that I last saw the  
deceased alive on April 24, 1950, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Thomas F. White

M. D.

23B. ADDRESS

3809 Greenmount Ave

23C. DATE SIGNED

4/26/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/27/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 27 1950

REGISTRAR'S SIGNATURE

L. Williams, M.D.

25. FUNERAL DIRECTOR

WIEDFELD &amp; SON

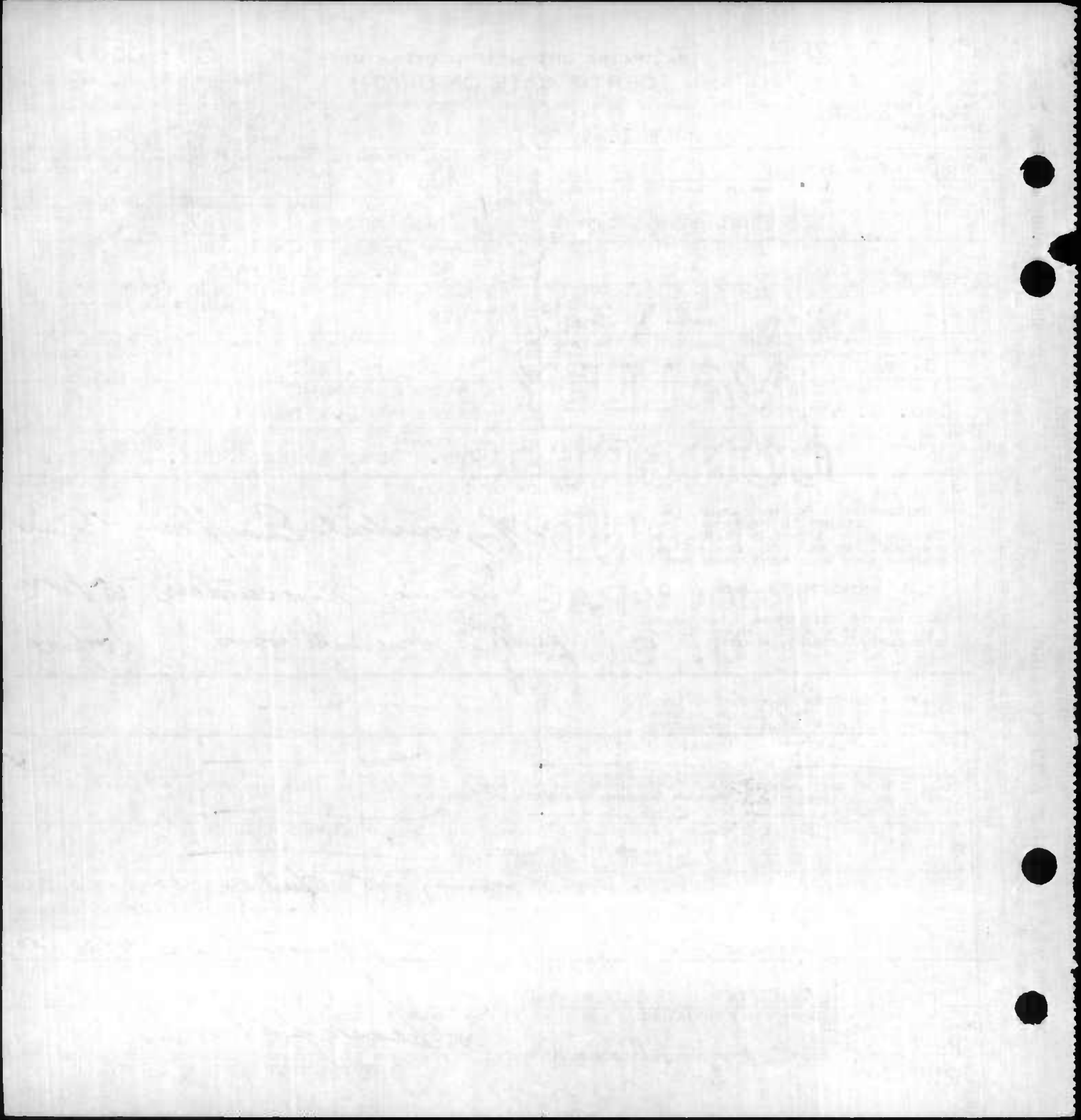
ADDRESS

GREENMOUNT AVE &amp; 22ND

APR 27 1950

26690

937



425

M M 137503

50

3896

BALTIMORE CITY HEALTH DEPARTMENT

50

3896

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Fritz, Volkening

2. DATE  
OF  
DEATH

April 26-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Baltimore City Hospitals

INSTITUTION

4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

39 S. Carey St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1872?

9. AGE (in years)

last birthday

If Under 1 Year

Months; Days

If Under 24 Hours

Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labourer

10B. KIND OF BUSINESS OR INDUSTRY

City of Balt

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MARRIAGE NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

B.C.H. Records 4940 Eastern Ave.

18. 443X I

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic Cardiovascular Disease

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ No ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 22, 1950 to April 26, 1950, that I last saw the deceased alive on April 26, 1950 and that death occurred at 11:45 PM, from the causes and on the date stated above.

23A. SIGNATURE

B. Cohen

M. O.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

2-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

St. Luke

24D. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Christington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wickham &amp; Sons 1214 St. Paul

APR 27 1950

VS 150

93D

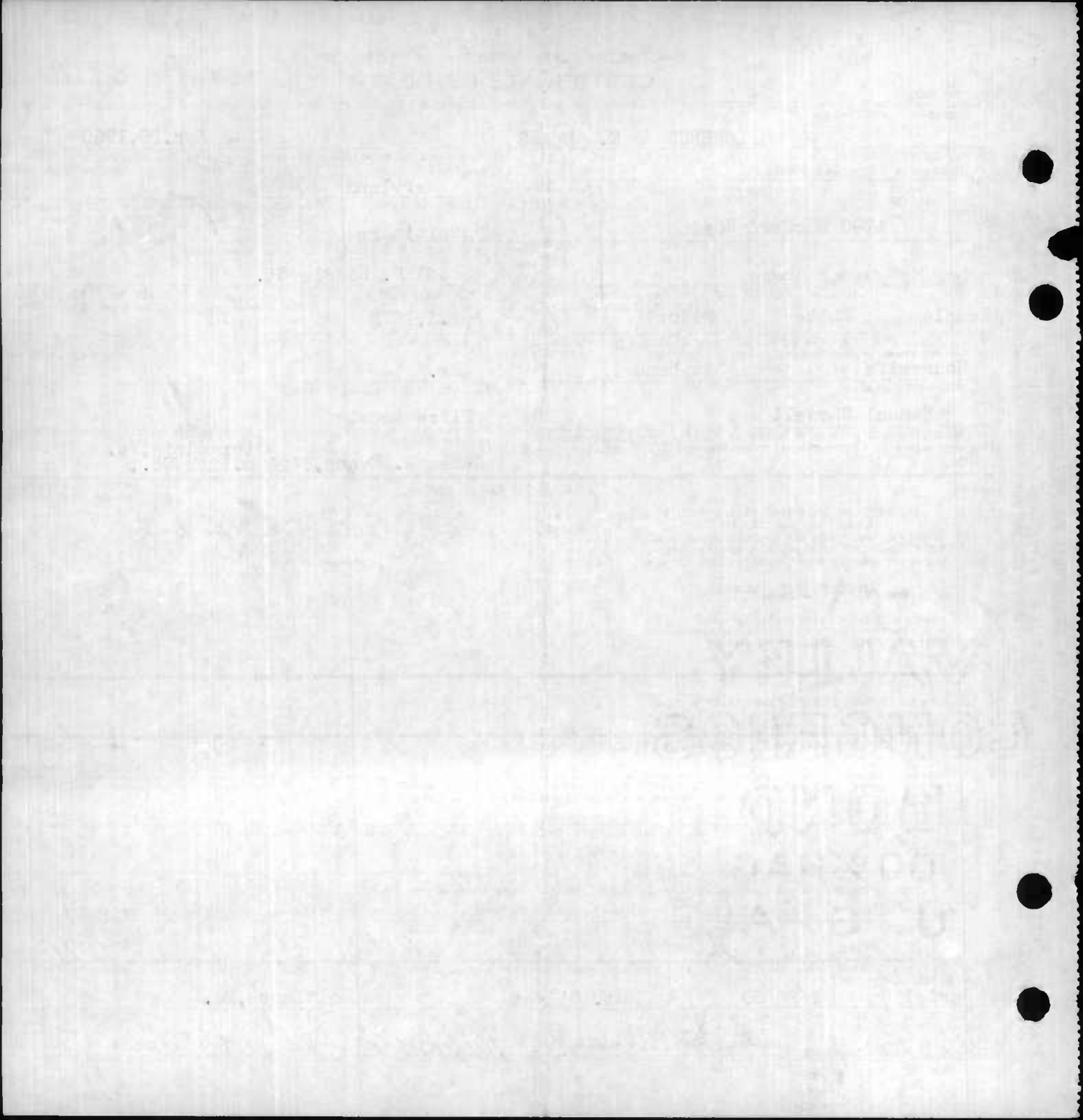


BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3897

BIRTH NO.		FLORENCE E. EVANS		2. DATE OF DEATH Apr. 26, 1950	
1. NAME OF DECEASED (Type or Print)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
3. PLACE OF DEATH: A. Baltimore City, Maryland				A. STATE Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 40 4700 Harford Road				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01	
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) 421 E. Biddle St.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Apr. 3, 1872	9. AGE (In years last birthday) 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Pa.	
13. FATHER'S NAME Samuel Shewell				12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME Eliza Ludwig	
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS James M. Evans, 1424 n. 12th St., Alexandria, Va.	
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Arteriosclerotic Cardio-Vascular Disease DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 7					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from April 17, 1950, to April 26, 1950, that I last saw the deceased alive on 4/26 1950, and that death occurred at m., from the causes and on the date stated above.					
23A. SIGNATURE James M. Evans		23B. ADDRESS 115th Calver St. M. D.		23C. DATE SIGNED 4/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. DATE RECEIVED BY LOCAL REGISTRAR APR 27 1950		25. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
VS 150		25. FUNERAL DIRECTOR William G. ...		25. ADDRESS 12151 ...	

131a





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3898

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN HENRY RIEBELING

2. DATE  
OF  
DEATH Apr. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or  
location)

1105 Sargeant St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1105 Sargeant St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

June 29, 1869

9. AGE (In years  
last birthday)

80

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Machinist, retired

10B. KIND OF BUSINESS OR  
INDUSTRY

B &amp; O R.R.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Katherine Burk

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Wm F. Siegling, 1529 Northwick Road.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Myocarditis  
DUE TO

2 months

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Bronchitis + Asthma  
DUE TO  
(C)

6 years

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 3rd, 1950 to Apr. 27, 1950 that I last saw the  
deceased alive on Mar 27, 1950 and that death occurred at 11:00 pm., from the causes and on the date stated above.

23A. SIGNATURE

H. H. Kates

M. D.

23B. ADDRESS

517 Scott St.

23C. DATE SIGNED

Apr. 27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

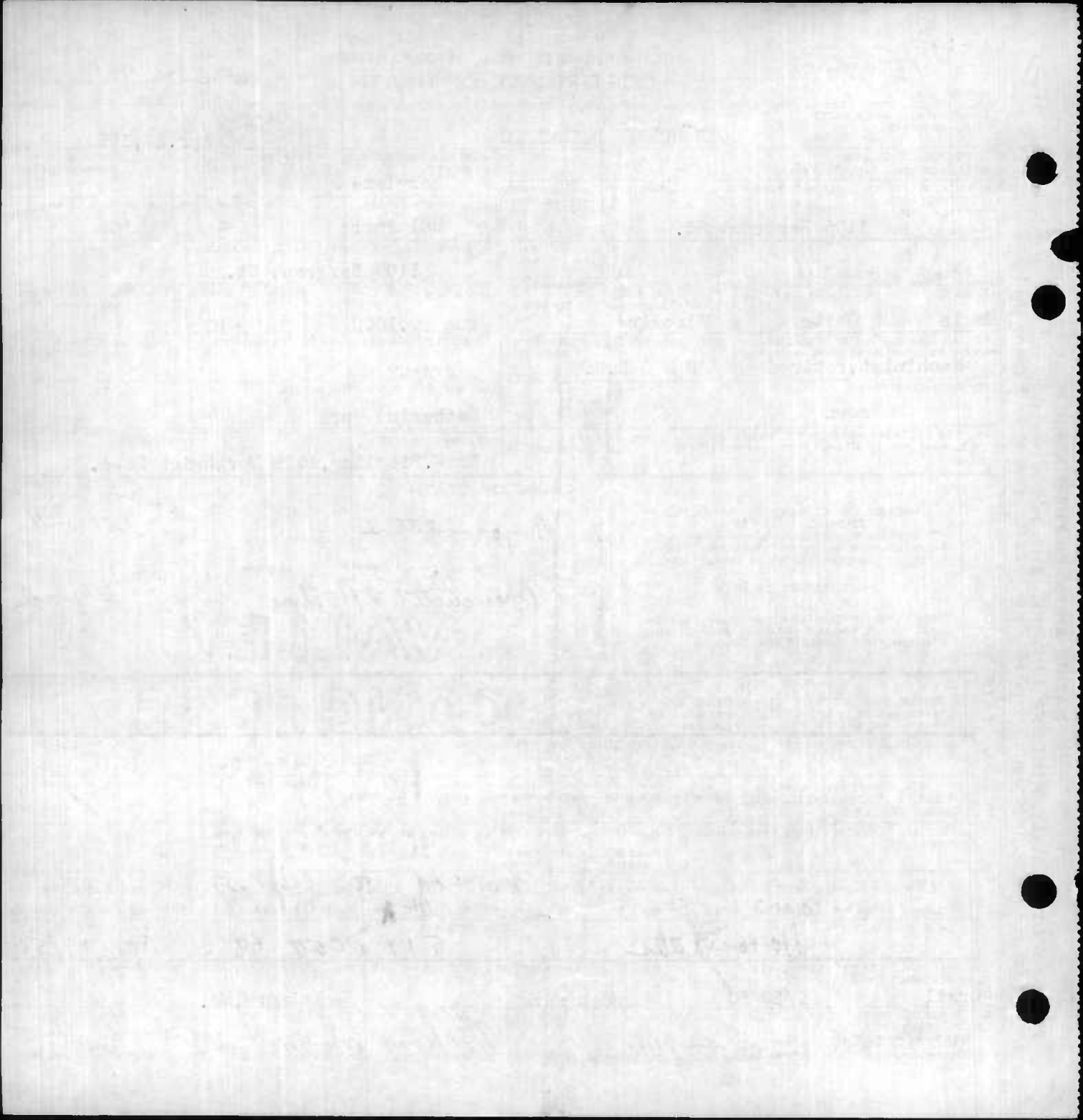
ADDRESS

W. H. Kates 1215 St Paul St

APR 27 1950

VS 150

93E



B-62950 3899

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3899  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William N. Bowers

2. DATE  
OF  
DEATH

4/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR  
INSTITUTION

Beech Hill Nursing Home

C. CITY OR TOWN

Balto

8-01

(If outside corporate limits, write RURAL and give  
township)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3320 Lyndale Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5/8/1892

9. AGE (In years  
last birthday)

77

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR  
INDUSTRY

B &amp; O R.R.

11. BIRTHPLACE (State or foreign country)

W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John W. Bowers

14. MOTHER'S MAIDEN NAME

Elizabeth Rodrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Harry E. Bowers 3320 Lyndale Ave

18.

334X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Broncho pneumonia, bilateral, terminal

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Cerebral arteriosclerosis

DUE TO

approx 2 yrs

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 May 1946, to 27 April 1950, that I last saw the  
deceased alive on 27 April 1950, and that death occurred at 730 m., from the causes and on the date stated above.

23A. SIGNATURE

Helen Williams

23B. ADDRESS

1513 N. Milton Ave

23C. DATE SIGNED

27 April 50

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

4/28/50

24C. NAME OF CEMETERY OR CREMATORY

Rosedale

24D. LOCATION (City, town, or county)

Martinsburg W. Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

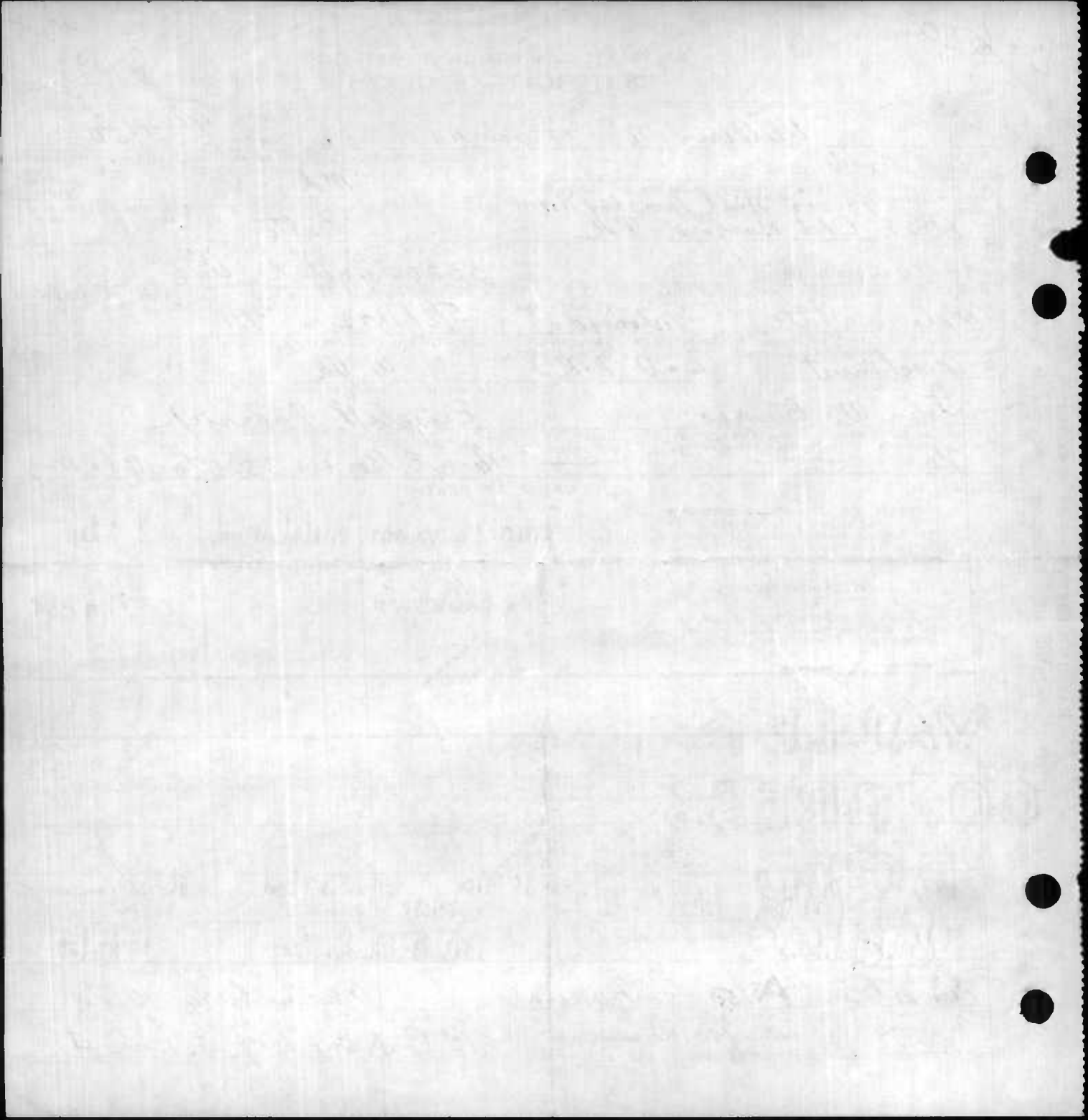
Wm. Cook, Inc. 1217 St. Paul St.

VS 150

107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully submitted. The  
correct age is especially important. Physicians: please write the causes of death clearly and legibly.



50 3900

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3900

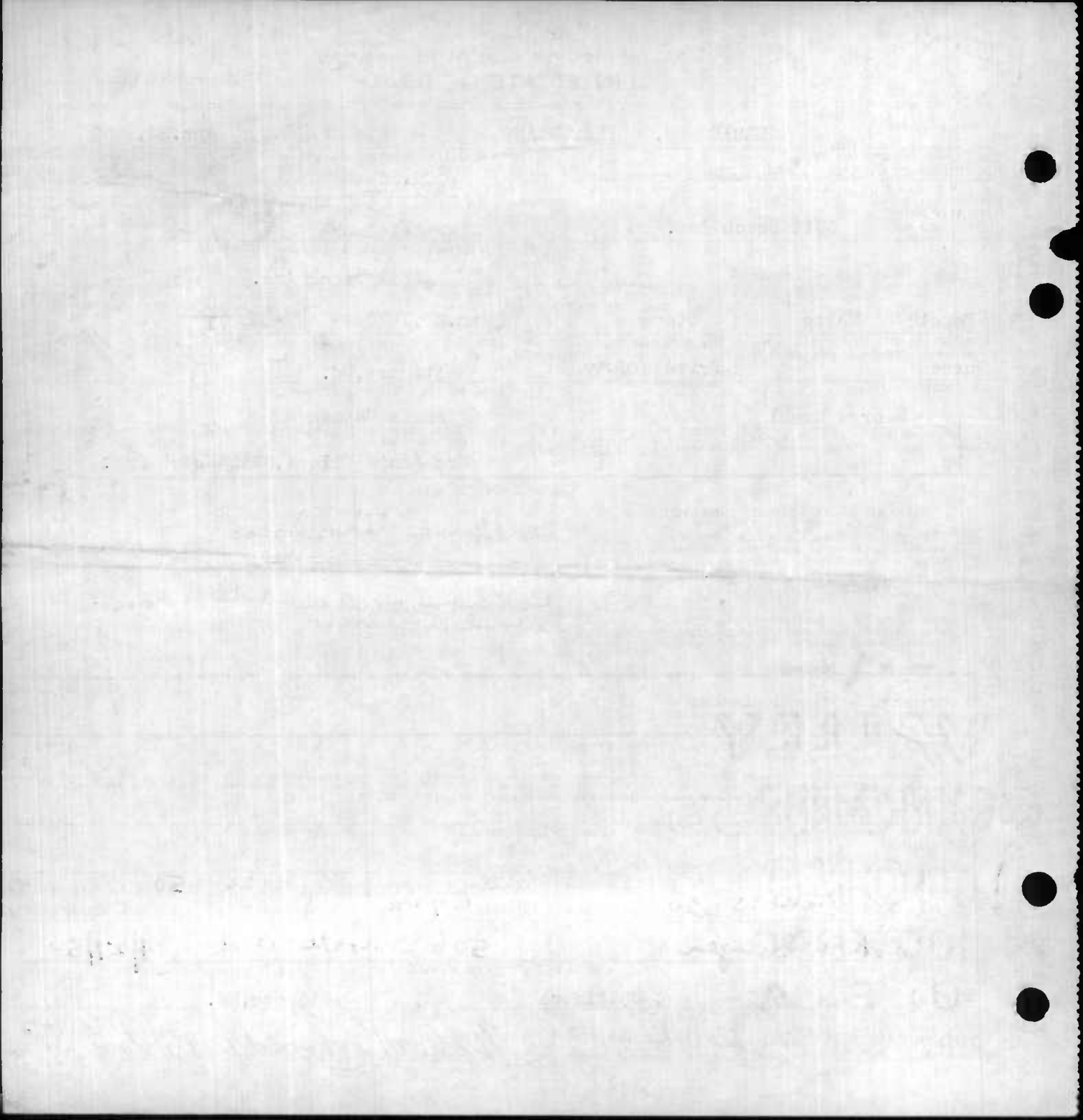
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		ELSIE C. TEMPLEMAN		Apr. 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 00 3311 Beech Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-06			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3311 Beech Ave.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan. 23, 1879	9. AGE (In years last birthday) 71	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10B. KIND OF BUSINESS OR INDUSTRY Private duty		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME George Ruehl		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Annie Ossman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Annie Wilcox, 3315 Beech Ave.	
18. 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO ANTECEDENT CAUSES (B) Cardiovascular-arteriosclerosis renal disease DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 1938, to April 26, 1950, that I last saw the deceased alive on April 25, 1950, and that death occurred at 7:30 a.m., from the causes and on the date stated above.					
23A. SIGNATURE Jack J. Singer		23B. ADDRESS M. D. 506 S. North Ave		23C. DATE SIGNED 4/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/50		24C. NAME OF CEMETERY OR CREMATORY Baltimore	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
DATE RECEIVED BY LOCAL REGISTRAR APR 27 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR Thomson (on Ind 12/1/51) Paul St	

VS 150

V3692

131a





L-132  
50 3901  
CERTIFICATE CORRECTED

5-9-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 3901

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEBOWITZ, SAMUEL Y

2. DATE  
OF  
DEATH

4/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Caucasian

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M.

8. DATE OF BIRTH

9. AGE (In years  
at birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

49-63

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Draftsman

10B. KIND OF BUSINESS OR  
INDUSTRY

BLDG. CONST.

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Sophie Lebowitz 5101 Sunmore Ave

18.

163X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

Carcinoma of right lung

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

4/26/50

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/25/50, to 4/27, 1950, that I last saw the  
deceased alive on 4/27, 1950, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

P. Leonard Desser

M. D.

23B. ADDRESS

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMA-  
TION: REMOVAL (Specify)

Burial

24B. DATE

4-28-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Mt Carmel

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 27 1950

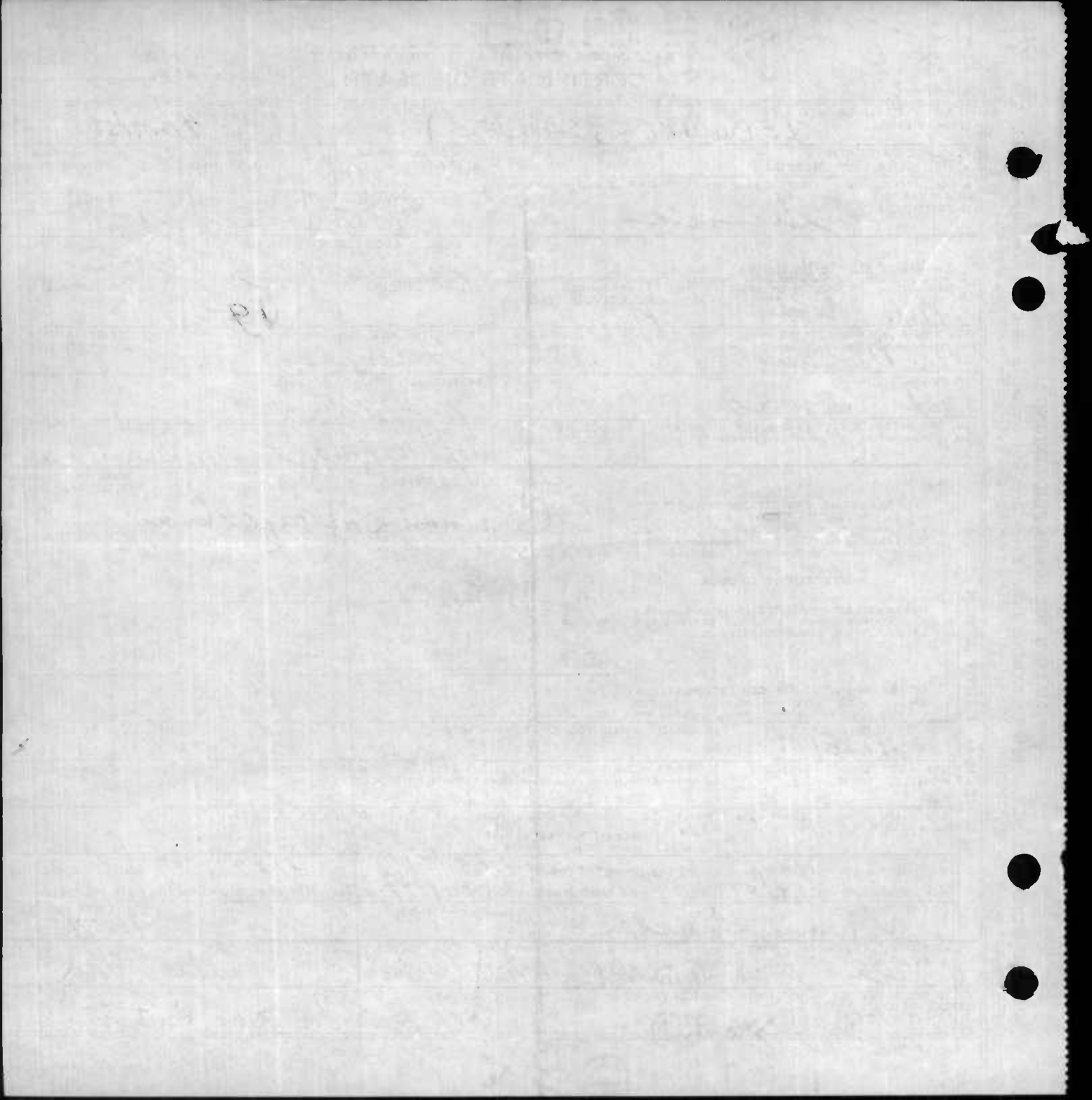
REGISTRAR'S SIGNATURE

Huntington Williams, Md

25. FUNERAL DIRECTOR

Jack Lewis, Inc 2100 Eutan Rd

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50-28162

50 3902

1. NAME OF DECEASED (Type or Print) <b>Mark Theodore Silver</b>			2. DATE OF DEATH <b>Apr. 23, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>15-12</b>		
C. Length of stay in Baltimore <b>3 days</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2330 Druid Park Drive # 15</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>Apr. 20, 1950</b>		9. AGE (In years last birthday) <b>3</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Daniel Nathan Silver</b>			14. MOTHER'S MAIDEN NAME <b>Bernice Sperling</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs Bernice Silver, 2330 Druid Park, Dr.</b>		

18. <b>776 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <b>Prematurity</b>			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>April 20, 1950</b> , to <b>April 23, 1950</b> , that I last saw the deceased alive on <b>April 23, 1950</b> , and that death occurred at <b>10<sup>15</sup> a.m.</b> , from the causes and on the date stated above.						
23A. SIGNATURE <b>Robert Weiss</b>		23B. ADDRESS <b>Sinai Hospital</b> M. D.		23C. DATE SIGNED <b>4-25-50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>JOHN HOPKINS MEDICAL SCHOOL</b>		
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)		
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 27 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Commissioner of Health</b>		



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W-362  
50 3903BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3903

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emanuel Waters

2. DATE  
OF  
DEATH

4-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

Balto.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

Provident Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

17-03

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

807 Edmondson Ave

5. SEX

Male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months Days If Under 24 Hours Hours Min.

50 ±

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr + Mrs. David Mansell Same

18. 420.1 I

CAUSE OF DEATH

ATTACK

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary attack

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from 4-26-1950, to 4-21-1950, that I last saw the deceased alive on 4-21, 1950, and that death occurred at 10<sup>45</sup> m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL APR 25 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

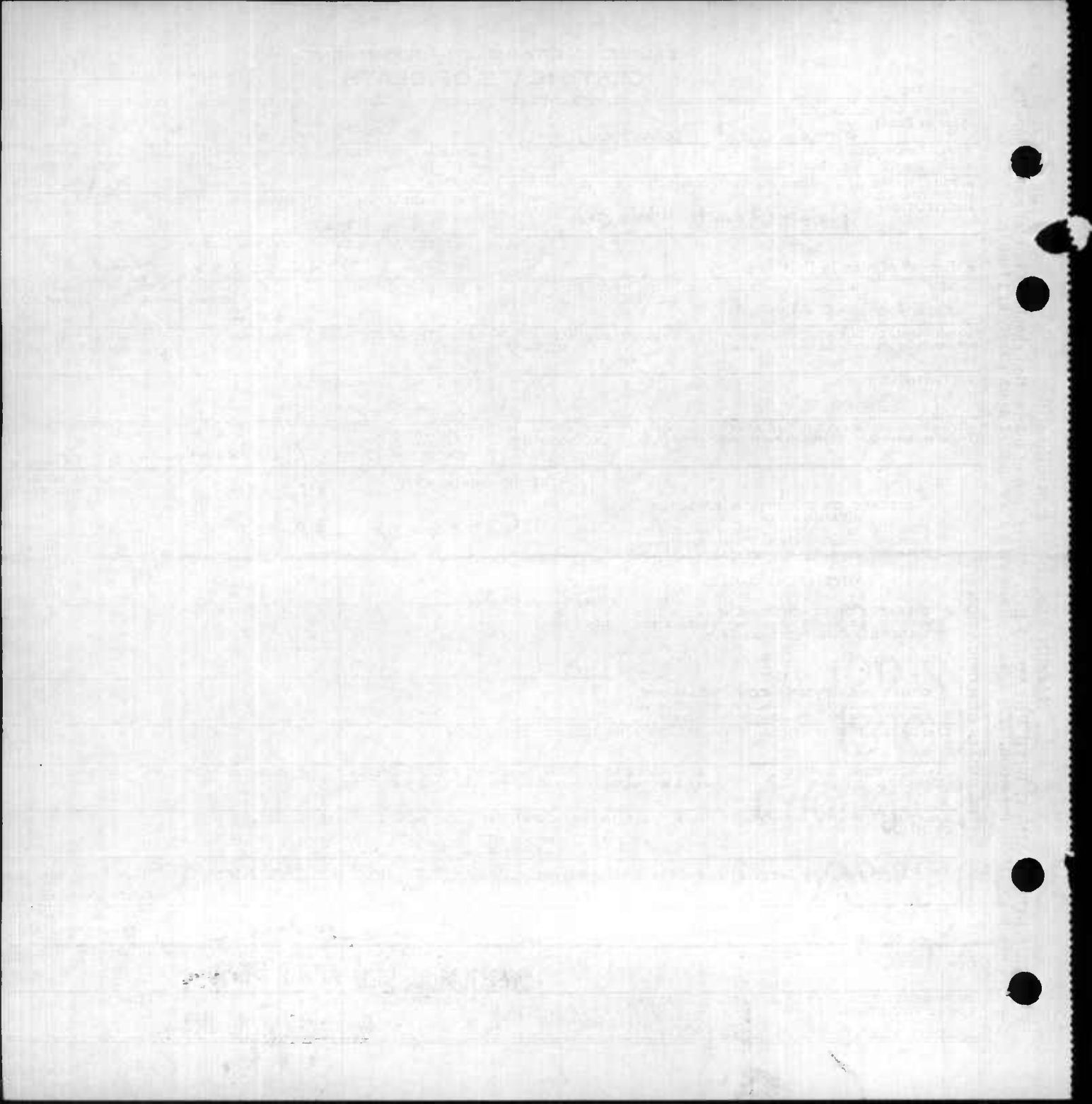
ADDRESS

APR 27 1950  
VS 150

T. H. Williams, M.D.

Commissioner of Health

94a





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3904

BIRTH NO.

JAL- 137365

1. NAME OF DECEASED  
(Type or Print)

Frank Costanzo

2. DATE  
OF  
DEATH

4-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Baltimore City Hospital

4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6608 Falt Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

???

9. AGE (in years  
last birthday)

59

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR  
INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Pasqual

14. MOTHER'S MAIDEN NAME

Thelma

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of the Stomache

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

4-25-50

19B. MAJOR FINDINGS OF OPERATION

Intestinal obstruction from above

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-17-50, 1950, to April 26, 1950, that I last saw the  
deceased alive on April 26, 1950, and that death occurred at 9.15 PM, from the causes and on the date stated above.

23A. SIGNATURE

J. S. Ozer

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-27-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

April 28, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltor National

24D. LOCATION (City, town, or county)

Fredrick Road

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

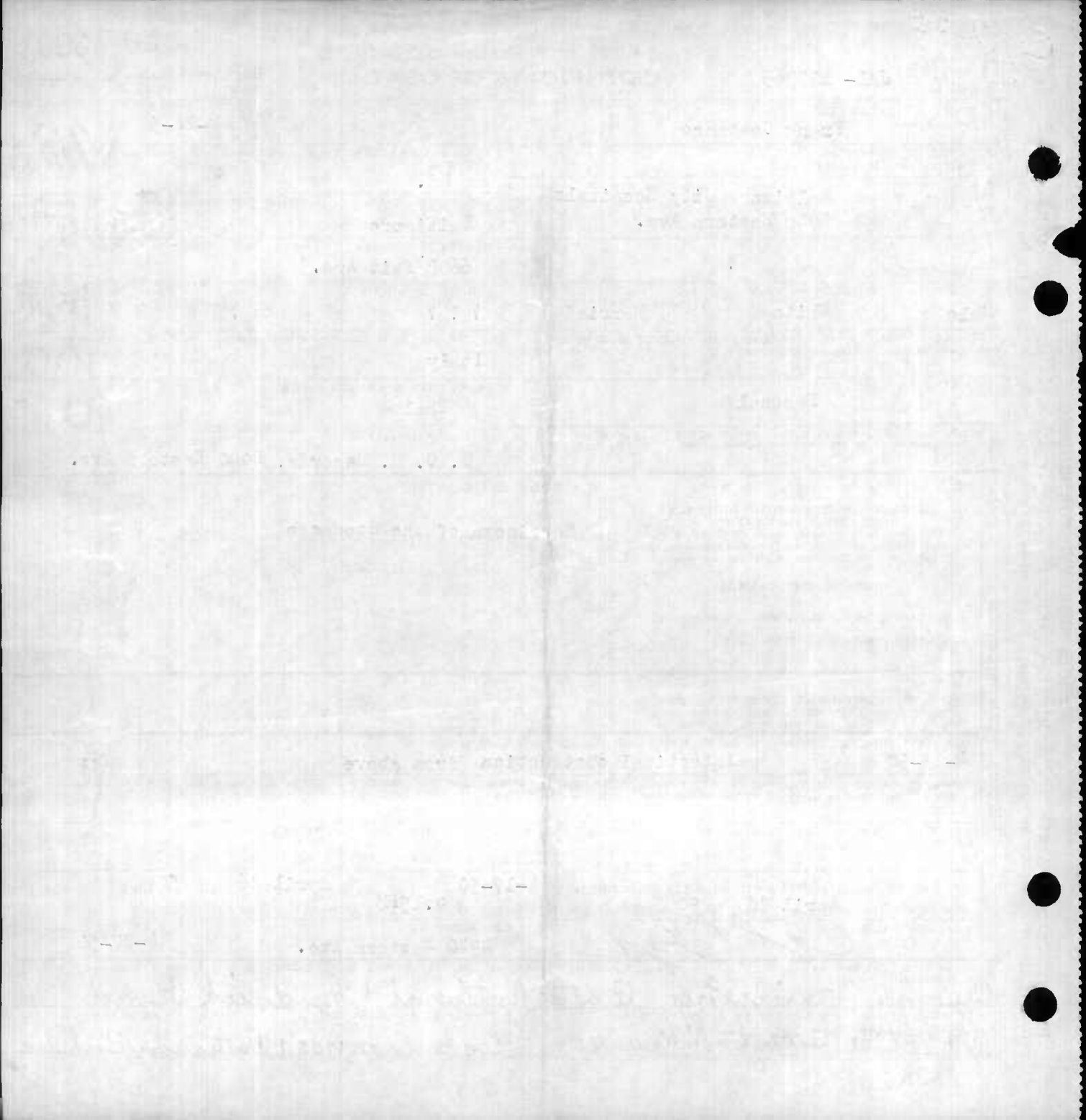
Leo S. Cook, 1703 N. Patterson Park Ave.

VS 150

APR 28 1950

9FF47

46B



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3905BIRTH NO. 49-180361. NAME OF DECEASED  
(Type or Print)Robert ROGERS, Jr.2. DATE  
OF  
DEATHApril 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION 1206 H Court

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1206 H. Court

C. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

C7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Single

8. DATE OF BIRTH

Sept. 10, 19499. AGE (In years  
last birthday)If Under 1 Year  
Months: Days8If Under 24 Hours  
Hours: Min.1710A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRYNone

11. BIRTHPLACE (State or foreign country)

Baltimore12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robert Rogers, Sr.

14. MOTHER'S MAIDEN NAME

Cornelia Turner15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Robert Rogers, 1206 H Court18. 053.2

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Septicemia  
DUE TO pneumococcus

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO \_\_\_\_\_

(C) \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Acute upper respiratory infection

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

April 28, 195024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 28 1950Wilmington Williams, M.D.Frances A. Hemmley 578 N. Biddle St.

16020-05

MARGIN RESERVED FOR BINDING

H-400 50 3906

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3906

BIRTH NO.		1. NAME OF DECEASED (Type or Print) REGINA HALL		2. DATE OF DEATH April 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparrows Point			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) Box 366 Route 10			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Nov. 19, 1936	9. AGE (In years last birthday) 13	10. USUAL OCCUPATION (Give kind of work done during most of working life. Also if retired) Student
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Also if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Albert J. Hall		14. MOTHER'S MAIDEN NAME Helin F. Seay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Helin F. Seay, Sparrows Pt. Md.	
18. E 8124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Crushing injury to left chest		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
(B) DUE TO					
(C) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) highway		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Point Rd. North Point Dual Highway & Old North	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY April 27, 1950 12 midnight		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by auto while awaiting bus	
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Russell S. Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED April 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/29/50		24C. NAME OF CEMETERY OR CREMATORY Mountland Memorial	
24D. LOCATION (City, town, or county) Baltimore Md.		25. FUNERAL DIRECTOR Roland L. Fisher, 2112 Dandale Ave		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR APR 28 1950		REGISTRAR'S SIGNATURE T. Williams			

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1899

ALBANY:

WILLIAM H. SAWYER, PRINTER.

1901.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-400 50 3907

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 58-3907

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>EDNA HALL</b>			2. DATE OF DEATH <b>April 27, 1950</b>			
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>						
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Sparrows Point</b>						
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>Box 366 Route 10-1226 Forest Road</b>						
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Aug. 21, 1933</b>			9. AGE (In years last birthday) <b>16</b>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Sparrows Point, Md.</b>			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Albert J. Hall</b>			14. MOTHER'S MAIDEN NAME <b>Helen F. Leay</b>			15. WAS DECEASED MEMBER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.
17. INFORMANT <b>Helen Diegel, Sparrows Pt., Md.</b>			ADDRESS			18. <b>E812.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Craneo-cerebral injuries and traumatic amputation of left leg</b>			INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(B)			(C)			
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Point Rd. North Point Dual Highway &amp; Old North</b>			
21D. TIME (Month) (Day) (Year) (Hour) <b>April 27, 1950 12 midnight</b>			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? Pedestrian struck by auto while awaiting bus			
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .									
23A. SIGNATURE <b>R. S. Fisher</b>			23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D.			23C. DATE SIGNED <b>April 27, 1950</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>April 29, 1950</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>			
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			25. FUNERAL DIRECTOR <b>Roland L. Fisher, 2412 Dundalk Ave.</b>			ADDRESS			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 28 1950</b>			REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>						

VS 151

N-804.2

170c

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of school		22. Signature of employer		23. Signature of business		24. Signature of government	
25. Signature of military		26. Signature of naval		27. Signature of air force		28. Signature of space	
29. Signature of intelligence		30. Signature of defense		31. Signature of justice		32. Signature of education	
33. Signature of health		34. Signature of labor		35. Signature of commerce		36. Signature of agriculture	
37. Signature of industry		38. Signature of science		39. Signature of art		40. Signature of religion	
41. Signature of culture		42. Signature of sports		43. Signature of recreation		44. Signature of entertainment	
45. Signature of media		46. Signature of communication		47. Signature of transportation		48. Signature of infrastructure	
49. Signature of utilities		50. Signature of services		51. Signature of government		52. Signature of society	
53. Signature of community		54. Signature of nation		55. Signature of world		56. Signature of universe	
57. Signature of everything		58. Signature of nothing		59. Signature of somewhere		60. Signature of nowhere	
61. Signature of when		62. Signature of how		63. Signature of why		64. Signature of what	
65. Signature of who		66. Signature of which		67. Signature of whose		68. Signature of whom	
69. Signature of whose		70. Signature of whose		71. Signature of whose		72. Signature of whose	
73. Signature of whose		74. Signature of whose		75. Signature of whose		76. Signature of whose	
77. Signature of whose		78. Signature of whose		79. Signature of whose		80. Signature of whose	
81. Signature of whose		82. Signature of whose		83. Signature of whose		84. Signature of whose	
85. Signature of whose		86. Signature of whose		87. Signature of whose		88. Signature of whose	
89. Signature of whose		90. Signature of whose		91. Signature of whose		92. Signature of whose	
93. Signature of whose		94. Signature of whose		95. Signature of whose		96. Signature of whose	
97. Signature of whose		98. Signature of whose		99. Signature of whose		100. Signature of whose	

D-142 50 3908

## BALTIMORE CITY HEALTH DEPARTMENT

50 3908

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MR. Mike Diapoulos

DIAPOLIS

DIAPOLIS (mp)

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1708 Aliceanna Street

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

1-15-1900

9. AGE (In years  
last birthday)

50

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

Writer

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-18-2193

17. INFORMANT

ADDRESS

Menelaos Diapoulos 4112 Ave J

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

April 26, 1950

24A. (BURIAL, CREMA-  
TION, REMOVAL) (Specify)

24B. DATE

4-27-50

24C. NAME OF CEMETERY OR CREMATORY

National Cem.

24D. LOCATION (City, town, or county)

Frederick Rd.

(State)

DATE RECEIVED BY  
APR 26 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

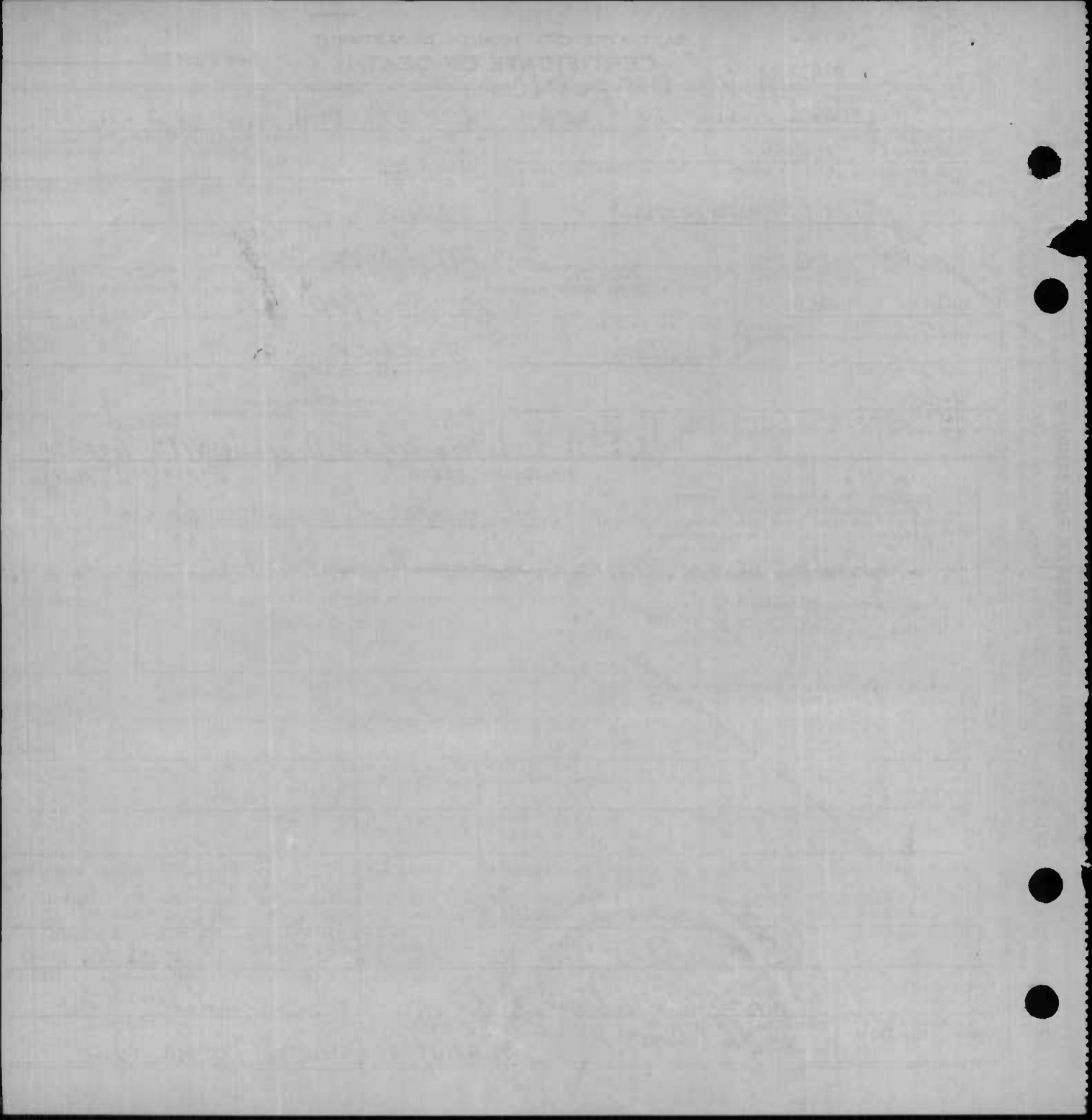
25. FUNERAL DIRECTOR

ADDRESS

Lambros funeral Home. Inc

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY, WITH UNFADING INK. Every item of information should be carefully stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



B-622

50 3909

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3909  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Susan Frances Burgess

2. DATE  
OF  
DEATH

April 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore, Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1905 Boone St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

1905 Boone St.

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

8 2 yrs.

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

March 27, 1868

9. AGE (In years, last birthday)

82

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Baltimore MD

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

John Zimmerman

14. MOTHER'S MAIDEN NAME

Susan Askey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Elmer Burgess. (son) 1905 Boone St.

18. 350X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal pneumonia

DUE TO

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Parkinson's Disease

DUE TO

8 yrs.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Arterio-sclerosis advd ase

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb. 17, 1945, to Apr. 27, 1950, that I last saw the deceased alive on Apr. 26, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

Charles H. Dargatz

23B. ADDRESS

3812 Pennmont Ave.

23C. DATE SIGNED

Apr. 27 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

5/1/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Glickner

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Glickner &amp; Son Baltimore

APR 28 1950

07 03131295

1700 3  
20  
1710 2

STATE OF CALIFORNIA  
COUNTY OF LOS ANGELES

City or town

$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

32

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-29-2007 BY 60322 UCBAW

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2012 2011 2010 2009 2008 2007 2006 2005 2004 2003 2002 2001 2000 1999 1998 1997 1996 1995 1994 1993 1992 1991 1990 1989 1988 1987 1986 1985 1984 1983 1982 1981 1980 1979 1978 1977 1976 1975 1974 1973 1972 1971 1970 1969 1968 1967 1966 1965 1964 1963 1962 1961 1960 1959 1958 1957 1956 1955 1954 1953 1952 1951 1950 1949 1948 1947 1946 1945 1944 1943 1942 1941 1940 1939 1938 1937 1936 1935 1934 1933 1932 1931 1930 1929 1928 1927 1926 1925 1924 1923 1922 1921 1920 1919 1918 1917 1916 1915 1914 1913 1912 1911 1910 1909 1908 1907 1906 1905 1904 1903 1902 1901 1900 1899 1898 1897 1896 1895 1894 1893 1892 1891 1890 1889 1888 1887 1886 1885 1884 1883 1882 1881 1880 1879 1878 1877 1876 1875 1874 1873 1872 1871 1870 1869 1868 1867 1866 1865 1864 1863 1862 1861 1860 1859 1858 1857 1856 1855 1854 1853 1852 1851 1850 1849 1848 1847 1846 1845 1844 1843 1842 1841 1840 1839 1838 1837 1836 1835 1834 1833 1832 1831 1830 1829 1828 1827 1826 1825 1824 1823 1822 1821 1820 1819 1818 1817 1816 1815 1814 1813 1812 1811 1810 1809 1808 1807 1806 1805 1804 1803 1802 1801 1800 1799 1798 1797 1796 1795 1794 1793 1792 1791 1790 1789 1788 1787 1786 1785 1784 1783 1782 1781 1780 1779 1778 1777 1776 1775 1774 1773 1772 1771 1770 1769 1768 1767 1766 1765 1764 1763 1762 1761 1760 1759 1758 1757 1756 1755 1754 1753 1752 1751 1750 1749 1748 1747 1746 1745 1744 1743 1742 1741 1740 1739 1738 1737 1736 1735 1734 1733 1732 1731 1730 1729 1728 1727 1726 1725 1724 1723 1722 1721 1720 1719 1718 1717 1716 1715 1714 1713 1712 1711 1710 1709 1708 1707 1706 1705 1704 1703 1702 1701 1700 1699 1698 1697 1696 1695 1694 1693 1692 1691 1690 1689 1688 1687 1686 1685 1684 1683 1682 1681 1680 1679 1678 1677 1676 1675 1674 1673 1672 1671 1670 1669 1668 1667 1666 1665 1664 1663 1662 1661 1660 1659 1658 1657 1656 1655 1654 1653 1652 1651 1650 1649 1648 1647 1646 1645 1644 1643 1642 1641 1640 1639 1638 1637 1636 1635 1634 1633 1632 1631 1630 1629 1628 1627 1626 1625 1624 1623 1622 1621 1620 1619 1618 1617 1616 1615 1614 1613 1612 1611 1610 1609 1608 1607 1606 1605 1604 1603 1602 1601 1600 1599 1598 1597 1596 1595 1594 1593 1592 1591 1590 1589 1588 1587 1586 1585 1584 1583 1582 1581 1580 1579 1578 1577 1576 1575 1574 1573 1572 1571 1570 1569 1568 1567 1566 1565 1564 1563 1562 1561 1560 1559 1558 1557 1556 1555 1554 1553 1552 1551 1550 1549 1548 1547 1546 1545 1544 1543 1542 1541 1540 1539 1538 1537 1536 1535 1534 1533 1532 1531 1530 1529 1528 1527 1526 1525 1524 1523 1522 1521 1520 1519 1518 1517 1516 1515 1514 1513 1512 1511 1510 1509 1508 1507 1506 1505 1504 1503 1502 1501 1500 1499 1498 1497 1496 1495 1494 1493 1492 1491 1490 1489 1488 1487 1486 1485 1484 1483 1482 1481 1480 1479 1478 1477 1476 1475 1474 1473 1472 1471 1470 1469 1468 1467 1466 1465 1464 1463 1462 1461 1460 1459 1458 1457 1456 1455 1454 1453 1452 1451 1450 1449 1448 1447 1446 1445 1444 1443 1442 1441 1440 1439 1438 1437 1436 1435 1434 1433 1432 1431 1430 1429 1428 1427 1426 1425 1424 1423 1422 1421 1420 1419 1418 1417 1416 1415 1414 1413 1412 1411 1410 1409 1408 1407 1406 1405 1404 1403 1402 1401 1400 1399 1398 1397 1396 1395 1394 1393 1392 1391 1390 1389 1388 1387 1386 1385 1384 1383 1382 1381 1380 1379 1378 1377 1376 1375 1374 1373 1372 1371 1370 1369 1368 1367 1366 1365 1364 1363 1362 1361 1360 1359 1358 1357 1356 1355 1354 1353 1352 1351 1350 1349 1348 1347 1346 1345 1344 1343 1342 1341 1340 1339 1338 1337 1336 1335 1334 1333 1332 1331 1330 1329 1328 1327 1326 1325 1324 1323 1322 1321 1320 1319 1318 1317 1316 1315 1314 1313 1312 1311 1310 1309 1308 1307 1306 1305 1304 1303 1302 1301 1300 1299 1298 1297 1296 1295 1294 1293 1292 1291 1290 1289 1288 1287 1286 1285 1284 1283 1282 1281 1280 1279 1278 1277 1276 1275 1274 1273 1272 1271 1270 1269 1268 1267 1266 1265 1264 1263 1262 1261 1260 1259 1258 1257 1256 1255 1254 1253 1252 1251 1250 1249 1248 1247 1246 1245 1244 1243 1242 1241 1240 1239 1238 1237 1236 1235 1234 1233 1232 1231 1230 1229 1228 1227 1226 1225 1224 1223 1222 1221 1220 1219 1218 1217 1216 1215 1214 1213 1212 1211 1210 1209 1208 1207 1206 1205 1204 1203 1202 1201 1200 1199 1198 1197 1196 1195 1194

100-2-371

[illegible]

法政司官



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3910612  
50 3910  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CLEAMENS KARFGIN</b>			2. DATE OF DEATH <b>April 26, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>4228 Loch Raven Blvd.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-09</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>4228 Loch Raven Blvd.</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Aug. 4, 1895</b>		9. AGE (In years last birthday) Months Days <b>54 yrs.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asso. Auditor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Cleamens Karfgin</b>			14. MOTHER'S MAIDEN NAME <b>Gertrude Esselman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Blanche V. Karfgin 4228 Loch Raven</b>		
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>April 25, 1950</b> to <b>April 26, 1950</b> , that I last saw the deceased alive on <b>4-26, 1950</b> , and that death occurred at <b>11:50 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Arthur Karfgin</b>		23B. ADDRESS <b>4230 Loch Raven Blvd.</b>		23C. DATE SIGNED <b>4-27-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/29/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 28 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. J. Fisher &amp; Sons Balto.</b>		ADDRESS <b>942 Md.</b>	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

PLANT RECORD

Section

Site

Plant Name

Number

Date

Collector

Locality

Altitude

Remarks

Number of Plants

Number of Fruits

Number of Leaves

Number of Flowers

Number of Stems

Number of Branches

Number of Seeds

Number of Pods

Number of Pods

Number of Pods

Number of Pods

Number of Pods

Number of Pods

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Number of Pods

Number of Pods

CERTIFICATE CORRECTED

5-2-50

50 3911

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3911

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM

BUCHHEIMER

2. DATE  
OF  
DEATH

4/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

822 N. BENTALOU ST.  
BALTO MD.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

822 N. BENTALOU ST

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTO MD.

16-05

c. Length of stay in Baltimore

LIFETIME

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

822 N. BENTALOU ST

5. SEX

M.

6. COLOR OR RACE

WHT

7. SINGLE, MARRIED,

WIDOWER, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG 12 - 1884

9. AGE (In years)

(6-6) 65

If Under 1 Year

Months: Days

8/16

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

BALTO TRANSIT CO

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

MATTHIAS BUCHEIMER

14. MOTHER'S MAIDEN NAME

HENRIETTA BAKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. MARY BUCHEIMER

18. 260X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

DIABETES MELLITUS

20 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

ARTERIOSCLEROSIS, GENERAL

?

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947 to April 27, 1950 that I last saw the deceased alive on April 27, 1950, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. H. H. H. H. H.

23B. ADDRESS

3534 Edmondson Ave

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMATION, OR OTHER

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

GEO. H. LEIMBACH

25. FUNERAL DIRECTOR

GEO. H. LEIMBACH

ADDRESS

528 N. LYMANS

Will call for  
Same Friday  
10am.



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

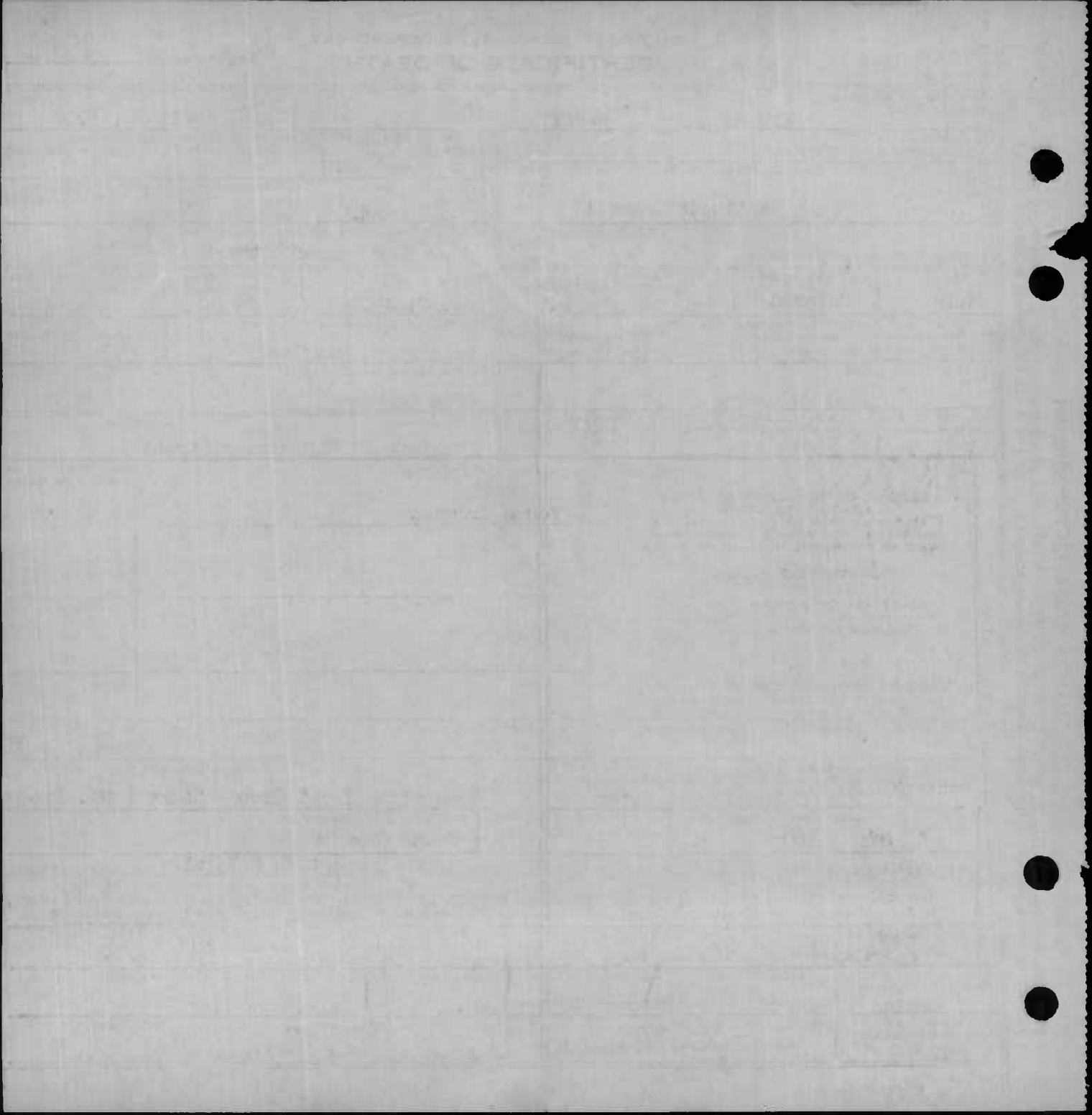
Registered No. 50 3912

1. NAME OF DECEASED (Type or Print) <b>EDWARD P. HENRY</b>			2. DATE OF DEATH <b>April 20, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>New York</b> B. COUNTY <b>V-29</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Brooklyn</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>813 Hancock Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Nov. 7, 1920</b>	9. AGE (In years last birthday) <b>29</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>station helper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steam Equipment</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charles Henry</b>			14. MOTHER'S MAIDEN NAME <b>Gran Cornish</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Eva Eads 819 Warner Street</b>		

18. <b>E 9-9-8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Found drowned</b> (A) ..... DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) ..... DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) .....		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Water</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Maryland Yacht Club - Hanover St. Bridge</b>		
21D. TIME (Month) (Day) (Year) (Hour) <b>4/20/50 6:00 P.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Found drowned</b>		
22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> .				
23A. SIGNATURE <i>Earl H. Boyer</i>	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <b>4/21/50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>April 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>	24D. LOCATION (City, town, or county) <b>Baltimore City</b>	(State)

DATE RECEIVED BY LOCAL REGISTRAR **APR 28 1950** REGISTRAR'S SIGNATURE *W. L. Williams, M.D.* 25. FUNERAL DIRECTOR **108 W** ADDRESS **J. L. Brown & Son - Montgomery St**





H-325

50 3913

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3913

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)*George R Hudson*2. DATE  
OF  
DEATH*April 26-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Md*

B. FULL NAME OF (If not in hospital or institution, give street address or location)

*3110 Reswick Rd*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore**13-05*

D. STREET ADDRESS (If rural, give location)

*3110 Reswick Rd*

c. Length of stay in Baltimore

*55 yrs*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

8. DATE OF BIRTH

*July 22 1867*

9. AGE (In years last birthday)

*82*

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Hosler (Retired) Penn. RR*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Md*

12. CITIZEN OF WHAT COUNTRY?

*USA*

13. FATHER'S NAME

*Jm Hudson*

14. MOTHER'S MAIDEN NAME

*Annie Perago*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*Yes*

16. SOCIAL SECURITY NO.

*none*

17. INFORMANT

*Sarah A. Hudson 3110 Reswick Rd*

ADDRESS

18. *422.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Bronchopneumonia - Bronchial 1 wk.*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *asthma - Cardiac Decomp.*

DUE TO

(C) *arteriosclerosis CVD**7.*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6-18*, 19*48*, to *4-26*, 19*50*, that I last saw the deceased alive on *4-27*, 19*50*, and that death occurred at *3 A* m., from the causes and on the date stated above.

23A. SIGNATURE

*Lawrence J. Hudson*

23B. ADDRESS

*3711 Fall Rd*

23C. DATE SIGNED

*4-27-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*April 29-1950*

24C. NAME OF CEMETERY OR CREMATORY

*Woodlawn*

24D. LOCATION (City, town, or county)

*Baltimore Md*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, Jr.*

25. FUNERAL DIRECTOR

*Frank J. Saitz*

ADDRESS

*814 2436 St.*

VS 150

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Page 2-2

M<sup>E</sup>GRANE  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3914  
Registered No. \_\_\_\_\_

BIRTH NO. *50 3914*

1. NAME OF DECEASED (Type or Print) <i>Eugene H. Mc Grane</i>			2. DATE OF DEATH <i>4/27/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Md.</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 9-08</i>		
C. Length of stay in Baltimore <i>Life</i> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>1224 Bonaparte Ave</i>		
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>aug 13, 1898</i>	9. AGE (In years last birthday) <i>51</i>	10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bus Tender</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>William Mc Grane</i>			14. MOTHER'S MAIDEN NAME <i>Mary Holmes</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <i>212-12-6515</i>	17. INFORMANT ADDRESS <i>Brother Joseph McGrane - Same</i>		

18. <i>581.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cirrhosis</i>		CAUSE OF DEATH (A) _____ DUE TO _____ (B) <i>Lower nephron nephrosis</i> DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>several years</i> <i>7 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>none</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April 14</i> 19 <i>50</i> , to <i>April 27</i> 19 <i>50</i> , that I last saw the deceased alive on <i>4/27</i> , 19 <i>50</i> , and that death occurred at <i>6:30</i> a.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>H. Reskin</i>		23B. ADDRESS <i>Mercy</i>		23C. DATE SIGNED <i>4/27/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/1/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25. FUNERAL DIRECTOR ADDRESS <i>L. J. Luck 5305 Harford Rd</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 28 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		71071	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Occupation		8. Cause of Death		9. Place of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Informant		13. Signature of Coroner		14. Signature of Medical Examiner		15. Signature of Funeral Home	
16. Signature of Burial Place		17. Signature of Cemetery		18. Signature of Interment		19. Signature of Burial		20. Signature of Burial	
21. Signature of Burial		22. Signature of Burial		23. Signature of Burial		24. Signature of Burial		25. Signature of Burial	
26. Signature of Burial		27. Signature of Burial		28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial		34. Signature of Burial		35. Signature of Burial	
36. Signature of Burial		37. Signature of Burial		38. Signature of Burial		39. Signature of Burial		40. Signature of Burial	
41. Signature of Burial		42. Signature of Burial		43. Signature of Burial		44. Signature of Burial		45. Signature of Burial	
46. Signature of Burial		47. Signature of Burial		48. Signature of Burial		49. Signature of Burial		50. Signature of Burial	
51. Signature of Burial		52. Signature of Burial		53. Signature of Burial		54. Signature of Burial		55. Signature of Burial	
56. Signature of Burial		57. Signature of Burial		58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial		64. Signature of Burial		65. Signature of Burial	
66. Signature of Burial		67. Signature of Burial		68. Signature of Burial		69. Signature of Burial		70. Signature of Burial	
71. Signature of Burial		72. Signature of Burial		73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial		79. Signature of Burial		80. Signature of Burial	
81. Signature of Burial		82. Signature of Burial		83. Signature of Burial		84. Signature of Burial		85. Signature of Burial	
86. Signature of Burial		87. Signature of Burial		88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial		94. Signature of Burial		95. Signature of Burial	
96. Signature of Burial		97. Signature of Burial		98. Signature of Burial		99. Signature of Burial		100. Signature of Burial	

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3915  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MARIE Vogler</b>		2. DATE OF DEATH <b>Apr. 27-1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>6305 Harford Road</b>		C. CITY OR TOWN <b>Baltimore</b> (If outside corporate limits, write RURAL and give township) <b>27-05</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>6305 Harford Road</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 11-1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT Home</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years - last birthday) <b>65</b> If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
13. FATHER'S NAME <b>Joseph Herb</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Christina Hipp</b>	
17. INFORMANT <b>Mrs. Lena Herb - 6305 Harford</b>		ADDRESS	

<p>18. <b>154X</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>Abdominal metastatic Carcinoma</b> DUE TO</p> <p>(B) <b>Carcinoma of the rectum</b> DUE TO</p> <p>(C) _____</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>1 yr</b></p> <p><b>?</b></p>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>January 1950</b> , to <b>April 27, 1950</b> , that I last saw the deceased alive on <b>April 27, 1950</b> , and that death occurred at <b>1 P. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>S. Deloren</b>		23B. ADDRESS <b>7122 Harford Rd, Balto 14</b>		23C. DATE SIGNED <b>April 27.50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-29-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>L. J. Reck</b>		ADDRESS <b>5305 Harford Rd</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 28 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>			

VS 150

46D

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Skioen



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3916

Registered No.

50 3916  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

George T Evans

2. DATE  
OF  
DEATH

April 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

27-06

D. STREET ADDRESS (If rural, give location)

2820 Hamilton Ave

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

St. Church Home &amp; Hospital

c. Length of stay in Baltimore

66

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Aug 26, 1983

9. AGE (In years,  
last birthday)

66

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR  
INDUSTRYB & RR  
Engineering

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

American

13. FATHER'S NAME

NIMROD EVANS

14. MOTHER'S MAIDEN NAME

Ellen O'Neil

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Dorothy Doen

Church Home Hosp

18.

177X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Adenocarcinoma prostate one 2 yrs.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

one month

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Apr. 17, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of prostate, bladder.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 15, 1950, to Apr 27, 1950, that I last saw the  
deceased alive on Apr 27, 1950 and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. M. Howard

23B. ADDRESS

Church Home Hospital

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

5/1/50

24C. NAME OF CEMETERY OR CREMATORY

Oaklawn

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

L. J. Luck, 5305 Harford Rd

ADDRESS

STATE OF TEXAS  
COUNTY OF DALLAS

NOTARY PUBLIC

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3917  
Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Arthur R. GRIFFIN		April 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-02	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 3 rd floor, 641 S. Paca St.	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH April 5, 1917
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Penna R.R.	9. AGE (In years last birthday) 33
13. FATHER'S NAME Francis Griffin		11. BIRTHPLACE (State or foreign country) Mitchellville, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
16. SOCIAL SECURITY NO. 711-07-9413		14. MOTHER'S MAIDEN NAME Mary Benson	
17. INFORMANT Mary Griffin		ADDRESS Elbridge Md.	

18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Hypertensive Cardiovascular Disease DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
---	---	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (a. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE J. S. Fisher	23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED April 25, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE April 25, 1950	24C. NAME OF CEMETERY OR CREMATORY National Cemetery
24D. LOCATION (City, town, or county) Baltimore, Md.	25. FUNERAL DIRECTOR Mrs. Katie R. Williams	ADDRESS 322 N 93D
DATE RECEIVED BY LOCAL REGISTRAR APR 28 1950	REGISTRAR'S SIGNATURE L. H. Williams	

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

State of New York

County of \_\_\_\_\_

City of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_

at \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*THOMAS, Charles.*

2. DATE  
OF  
DEATH

*4/26/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Maryland*

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

*Provident*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

*14-02*

D. STREET ADDRESS (If rural, give location)

*1409 Myrtle Ave.*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*Negro.*

7. SINGLE ☒ MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

*June 12, 1887*

9. AGE (In years last birthday)

*62*

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Laborer*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Oxford, Ind.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*George Thomas.*

14. MOTHER'S MAIDEN NAME

*Isabella*

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Grace Mason. 1409 Myrtle Ave.*

1B. *019.2*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Miliary Tuberculosis*

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4/19* 1950 to *4/26* 1950 that I last saw the deceased alive on *4/25* 1950, and that death occurred at *5:00* A. M., from the causes and on the date stated above.

23A. SIGNATURE

*John H. Holmes*

M. D.

23B. ADDRESS

*Provident Hosp.*

23C. DATE SIGNED

*4/26/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*April 29, 1950*

24C. NAME OF CEMETERY OR CREMATORY

*Mt. Zion*

24D. LOCATION (City, town, or county)

*Landedowne*

(State)

*md*

DATE RECEIVED BY LOCAL REGISTRAR

*APR 28 1950*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*The Katie R. Williams*

ADDRESS

*322 N School St*

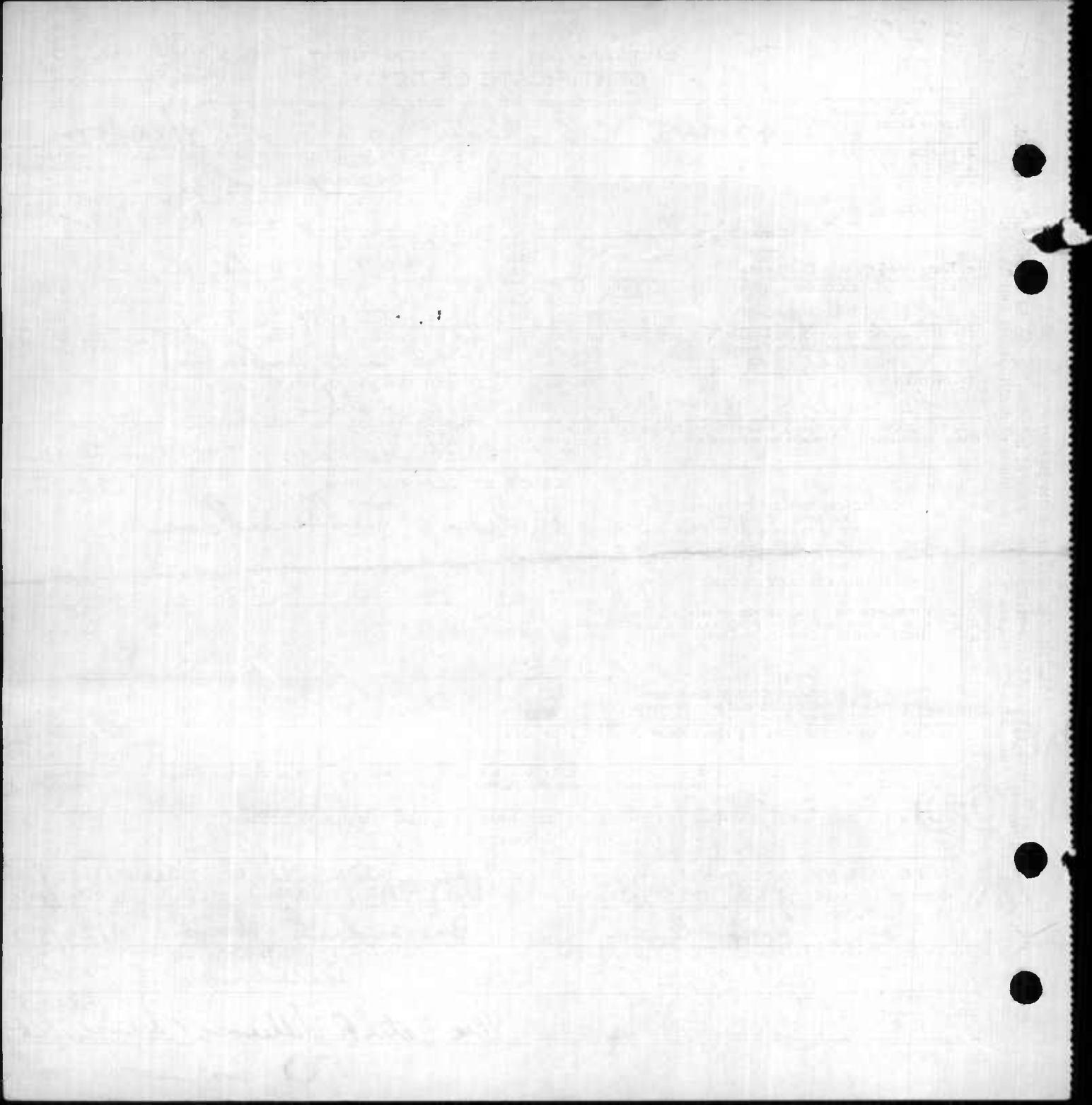
VS 150

*98899*

*13 B*

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3919

BIRTH NO. 50 3919		1. NAME OF DECEASED (Type or Print) <i>Henry Vogel</i>		2. DATE OF DEATH <i>4/26/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Balto.</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>West Balto General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto MD 27-17</i>			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>5125 Queensbury Ave</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M</i>	8. DATE OF BIRTH <i>Aug 11, 1892</i>	9. AGE (In years last birthday) <i>57</i>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>POLICEMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. City</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Joseph Vogel</i>		14. MOTHER'S MAIDEN NAME <i>Dora Paul</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Lena M. Vogel</i>	
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Pneumonia Disease</i>		19. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>P. J. ...</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>		23C. DATE SIGNED <i>4/26/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Apr 29/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>7 Holy Cross</i>	
24D. LOCATION (City, town, or county) (State) <i>Brooklyn, Md.</i>		25. FUNERAL DIRECTOR <i>Loring Bryan</i>		ADDRESS <i>5005 Ph Hyattsville</i>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3920  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

BIRDIE C. PREBBLE

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 5259 St. Charles Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

18. 443X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945 to April 25, 1950, that I last saw the  
deceased alive on April 24, 1950 and that death occurred at 3 A. M., from the causes and on the date stated above.

23. SIGNATURE

23. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Preble

F-614  
50 3921BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3921  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Nathan Frable

2. DATE  
OF  
DEATH

Apr. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 3-02D. STREET ADDRESS (If rural, give location)  
1149 E. Lombard St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9-11-79

9. AGE (in years  
last birthday)

10

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

unknown

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

unknown

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 356.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Amyotrophic lateral sclerosis

2 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

Pulmonary emphysema

10 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. ANATOMY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/23, 1950, to 4/27, 1950 that I last saw the  
deceased alive on 4/27, 1950 and that death occurred at 11:20 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Edy H. H. Schaefer

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

5/1/50

24C. NAME OF CEMETERY OR CREMATORY

Trinity Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

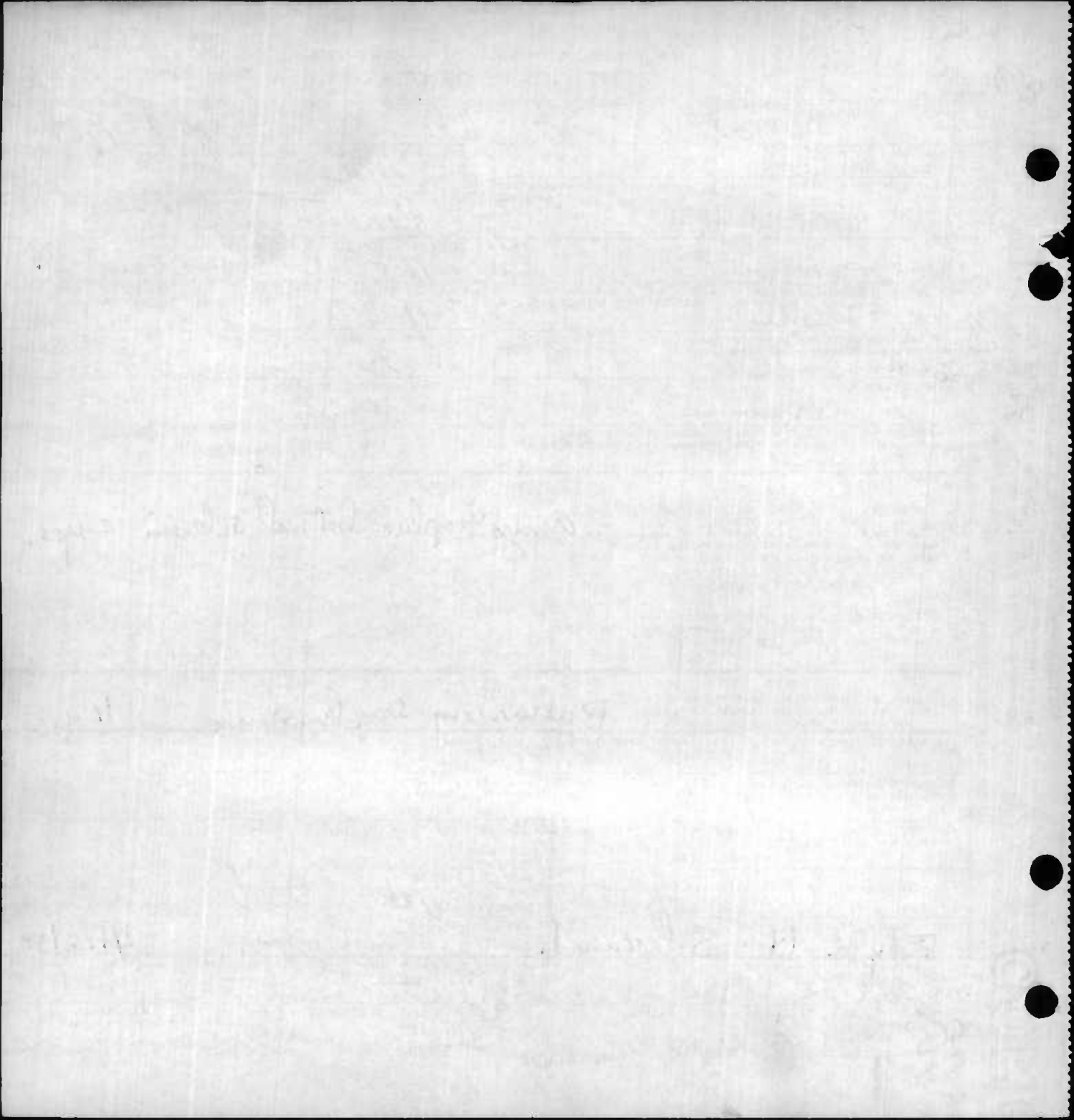
APR 28 1950

REGISTRAR'S SIGNATURE

Thurston Williams, M.D.

25. FUNERAL DIRECTOR

Sal. Leonard Bros. 114-26 W North Ave





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3922

BIRTH NO. 3922

1. NAME OF DECEASED  
(Type or Print)

Joseph A. Le Brou

2. DATE  
OF  
DEATH

4/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Rockdale

5300

D. STREET ADDRESS (If rural, give location)

3624

Hilmar Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

May 4, 1890

9. AGE (In years  
last birthday)

59

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR  
INDUSTRY

Tool Maker

13. FATHER'S NAME

Joseph A. Le Brou

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Anna Scharnagle

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

215-10-6821

17. INFORMANT

Mrs. Pauline Le Brou

ADDRESS

Rockdale  
3624 Hilmar Rd.

18.

162X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Bronchogenic Carcinoma

36 days

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Cerebral metastases

36 days

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/22, 1950, to 4/27, 1950, that I last saw the  
deceased alive on 4/27, 1950, and that death occurred at 11:4 m., from the causes and on the date stated above.

23A. SIGNATURE

Charles T. Henderson

M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

5/1/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

J. F. Lickner &amp; Sons, Balto., Md.

ADDRESS

STATE OF TEXAS  
COUNTY OF DALLAS

1911

March 10

Witness my hand and seal

at Dallas, Texas

Notary Public for the State of Texas

My commission expires

MARGIN RESERVED FOR BINDING

PLEASE WRITE IN INK ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

200

50 3923

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3923

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Prince Lewis</i>		2. DATE OF DEATH <i>April 27 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2824 Rayner Ave.</i>		C. CITY OR TOWN <i>Baltimore</i> (If outside corporate limits, write RURAL and give township) <i>16-06</i>	
c. Length of stay in Baltimore <i>25 Yrs</i>		D. STREET ADDRESS (If rural, give location) <i>2824 Rayner Ave.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept 21, 1908</i>
9. AGE (In years, last birthday) <i>41</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance</i>	
10A. KIND OF BUSINESS OR INDUSTRY <i>Peoples life ins.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Herbert Lewis</i>	
14. MOTHER'S MAIDEN NAME <i>Catherine Poole</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>212-03-0162</i>		17. INFORMANT ADDRESS <i>Margaret L. Lewis 2824 Rayner Ave.</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>002 X</i> <i>Massive Pulmonary Hemorrhage</i>	CAUSE OF DEATH (A) <i>Massive Pulmonary Hemorrhage</i> DUE TO (B) <i>Unknown cause.</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>over</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>—</i>		19B. MAJOR FINDINGS OF OPERATION <i>—</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>—</i>		21B. PLACE OF INJURY (a. g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>	
22. I hereby certify that I attended the deceased from <i>April 27, 1950</i> , to <i>April 27, 1950</i> , that I last saw the deceased alive on <i>April 27, 1950</i> , and that death occurred at <i>9:45 a. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Lesley A. Drall</i>		23B. ADDRESS <i>2950 Edmondson Ave</i>		23C. DATE SIGNED <i>4/27/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/29/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>—</i>		25. FUNERAL DIRECTOR <i>J. T. Stansbury</i>	
24F. REGISTRAR'S SIGNATURE <i>—</i>		24G. ADDRESS <i>2700 Edmondson Ave.</i>		24H. DATE <i>—</i>	

APR 28 1950

27480

13 B

Pulmonary tuberculosis.

Information obtained from Bureau of Tuberculosis 5/24/50.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3924

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Annie Blanche Kelly

2. DATE  
OF  
DEATH

April-28-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2130 Wicomico St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 25-03-BD. STREET ADDRESS (If rural, give location)  
2130 Wicomico St.

c. Length of stay in Baltimore

79

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

March-18-1871

9. AGE (in years,  
last birthday)

79

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Creamer

14. MOTHER'S MAIDEN NAME

Mary Benson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT ADDRESS  
Mrs. Annie Pickavance 2130 Wicomico St.

18. 442 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

cardio-vascular-renal disease

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

9 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from September 1949, to April-28, 1950, that I last saw the deceased alive on April-28, 1950, and that death occurred at 9<sup>04</sup> a. m., from the causes and on the date stated above.

23A. SIGNATURE

Walter H. Townsend

23B. ADDRESS

2708 Hollins Ferry Road

23C. DATE SIGNED

4/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

May 11, 1950

24C. NAME OF CEMETERY OR CREMATORY

Fountain PK

24D. LOCATION (City, town, or county) (State)

Frederick &amp; Pch

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

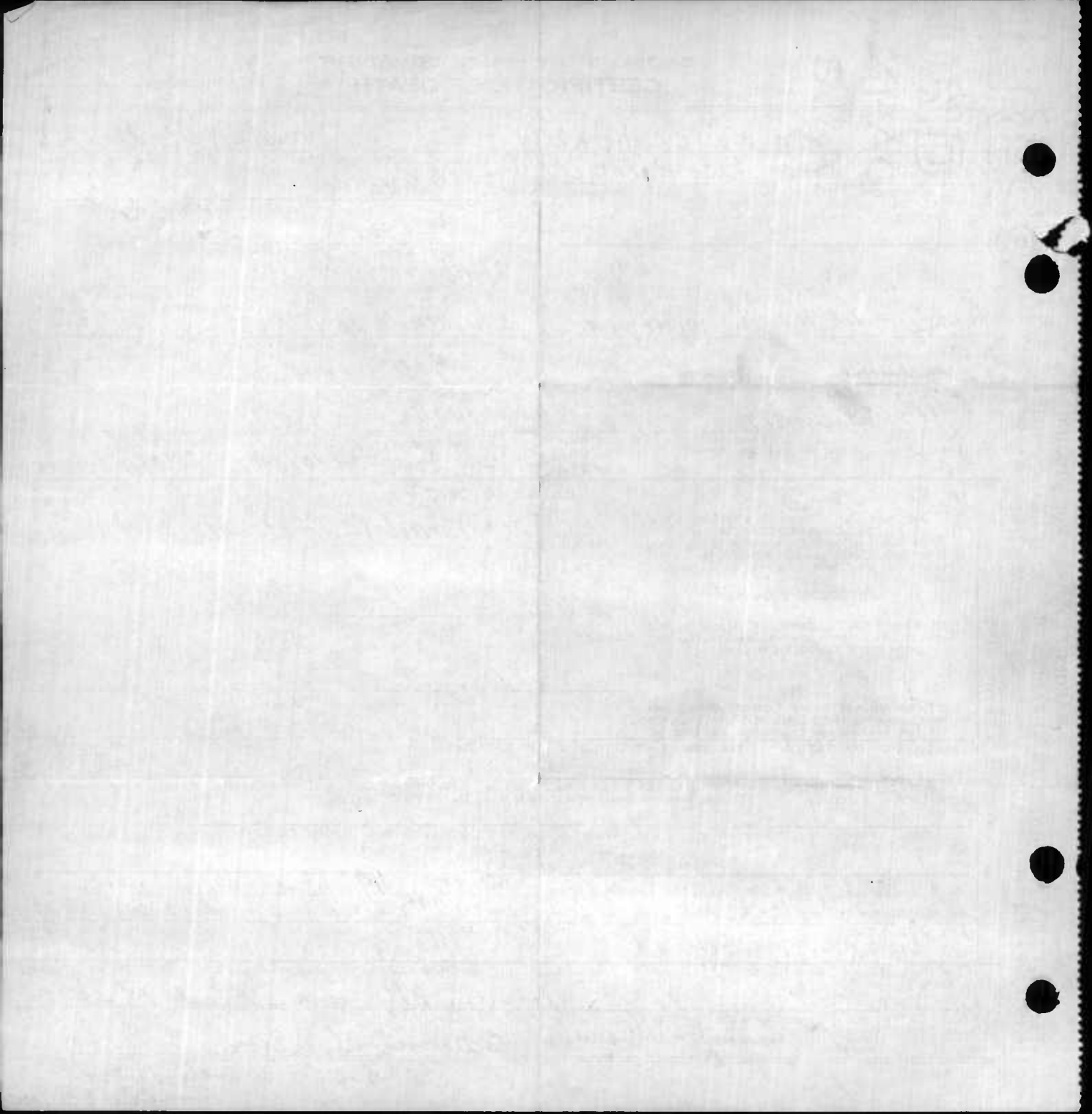
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Edward Towson

ADDRESS

131 a





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3925BIRTH NO. 50 39251. NAME OF DECEASED  
(Type or Print)<sup>DE</sup>  
Baby Mary Folk2. DATE  
OF  
DEATH

April 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

The Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1026 N. Broadway

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

April 17, 1950

9. AGE (In years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

3

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Benjamin Folk

14. MOTHER'S MAIDEN NAME

Mary Crawford

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Records

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Subarachnoid hemorrhage

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

1 minute

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Tentorial tear

(C)

Birth trauma

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 17, 1950, to April 17, 1950, that I last saw the  
deceased alive on April 17, 1950, and that death occurred at 1:28 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William L. Hartmann M. O.

23B. ADDRESS

601 N. Broadway

23C. DATE SIGNED

April 19, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 28 1950

Huntington Williams, M.D.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED

IN NEW YORK

THE DECEASED

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ON

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3926

BIRTH NO. 49-25916

1. NAME OF DECEASED  
(Type or Print)

BARBARA Ann Blekely

2. DATE  
OF DEATH

April 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Camp Haleberd, Md

D. STREET ADDRESS (If rural, give location)

26-13

c. Length of stay in Baltimore

6

5. SEX

7

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

11/25/49

9. AGE (In years  
last birthday)

5-4

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William R Blekely

14. MOTHER'S MAIDEN NAME

Nell Stuart

15. WAS DECEASED EVER IN U. S. ARMED FORCES  
(Yes, or no known) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Nell B. Stuart, Camp Haleberd, Md

18. 340.2 I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) respiratory failure

INTERVAL BETWEEN  
ONSET AND DEATH

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) internal hydrocephalus

DUE TO

(C) B. Coli meningitidis

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3/30/50

19B. MAJOR FINDINGS OF OPERATION

massive intracranial fibroses

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 11/25, 1949 to 4/28, 1950, that I last saw the  
deceased alive on 4/25, 1950, and that death occurred at 12 noon, from the causes and on the date stated above.

23A. SIGNATURE

David Joseph

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

8/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

1 May 1950

24C. NAME OF CEMETERY OR CREMATORY

Arlington National

24D. LOCATION (City, town, or county)

Arlington, Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 28 1950

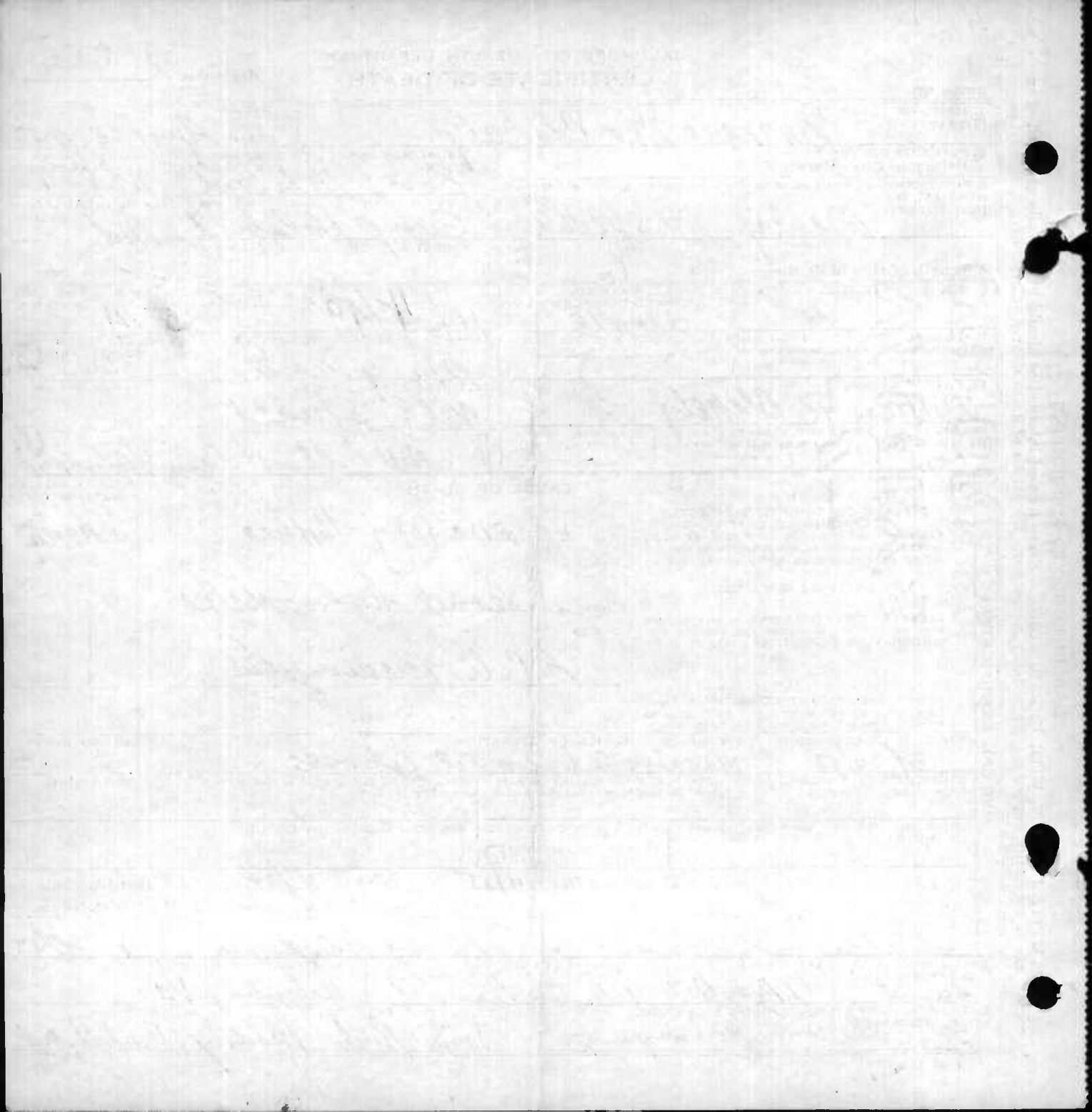
REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Walter Bush Bradley, Mendota, Md

ADDRESS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 3927

 BIRTH NO. 50 3927

1. NAME OF DECEASED (Type or Print) <b>SIMON M. KOELBELL or Koelbel</b>		2. DATE OF DEATH <b>April 27, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1933 Orleans St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>July 9 1891</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK Labor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>A.P. MEAT DEPT</b>	9. AGE (In years last birthday) <b>58</b>
11. BIRTHPLACE (State or foreign country) <b>Balto.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vitus Koelbel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Dumbrop</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-14-1446</b>	
17. INFORMANT <b>Anna Marshall</b>		ADDRESS <b>1933 Orleans St</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Heart Disease</b> DUE TO <b>Arterial Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
(C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

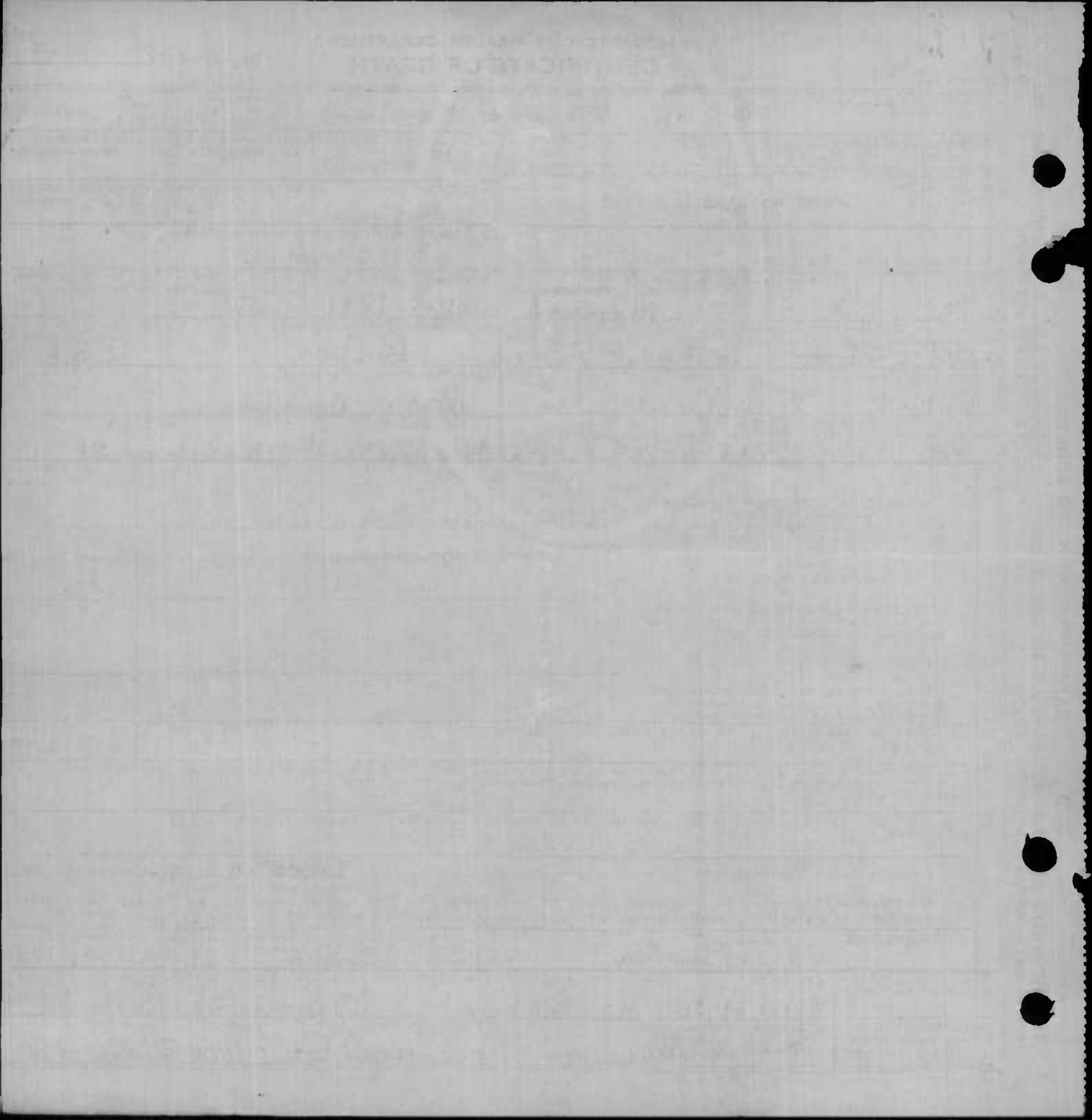
22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>RS Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>April 28, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>April 29-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>	24D. LOCATION (City, town, or county) (State) <b>Donnell St Balto. Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 28 1950</b>	REGISTRAR'S SIGNATURE <b>Wmington Williams, Jr.</b>	25. FUNERAL DIRECTOR <b>Doppel Bros. 1800 E Lombard St</b>	

VS 151

29861

93)





PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly and legibly. The age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3928

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Rose Zborowski

2. DATE  
OF  
DEATH

April 27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

4 N. Kenwood Ave

C. CITY OR TOWN

Balto.

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4 N. Kenwood Ave

c. Length of stay in Baltimore

68 Yrs.

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

April 3 1875

9. AGE (In years last birthday)

75

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Poland.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Kneavel

14. MOTHER'S MAIDEN NAME

Justina ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Frank H. Zborowski 4 N. Kenwood Ave

ADDRESS

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C. V. Disease.

DUE TO

3-26-49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial Failure

DUE TO

4-21-50

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☒ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

None

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

None.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

None

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

m.

21F. HOW DID INJURY OCCUR?

None

22. I hereby certify that I attended the deceased from 3-26-49, to 4-27, 1950, that I last saw the deceased alive on 4-26, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.

23A. SIGNATURE

J. Schinck

M. D.

23B. ADDRESS

8421 East Ave

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 1-1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Rosary

24D. LOCATION (City, town, or county)

German Hill Rd. Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Dyppel Bros 1800 E. Lombard St.

ADDRESS

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

N-425  
50 3929BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3929

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

JOHN H. NELSON

2. DATE  
OF  
DEATH

APRIL 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1127 GAY STREET

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

8-07

c. Length of stay in Baltimore

20YRS

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1127 GAY STREET.

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

AUG 20 1874

9. AGE (In years  
last birthday)

75

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR  
INDUSTRY

SEAFOOD

11. BIRTHPLACE (State or foreign country)

CRISFIELD MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE LAWSON NELSON

14. MOTHER'S MAIDEN NAME

ANDA ELIZABETH STERLING

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOSEPHINE M. NELSON 1127 GAY ST.

18.

332X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1948, to April, 1950, that I last saw the  
deceased alive on April 20, 1950, and that death occurred at 11 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Denis J. McGrath

23B. ADDRESS

1 E. Randall St.

23C. DATE SIGNED

4/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

APRIL 30 1950

24C. NAME OF CEMETERY OR CREMATORY

ASBURY M. E. CEM.

24D. LOCATION (City, town, or county)

CRISFIELD

(State)

MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Rippel Blvd 1800 E LOMBARD ST.

VS 150

8313

DR. MCGRAFF 15 RAMPALL ST

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3930

BIRTH NO. 50 3930

1. NAME OF DECEASED (Type or Print) Robert J. Stine (STINE)			2. DATE OF DEATH 4/26/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION SINAI 422 Madison Ave. N.Y.C.			C. CITY OR TOWN Baltimore 8-03		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 2409 E. Biddle St		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH June-16-1889	9. AGE (In years last birthday) 60	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Stine		14. MOTHER'S MAIDEN NAME Emma Ford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 214-14-2737		17. INFORMANT Katherine Stine-2409 E. Biddle St		ADDRESS	
18. 193 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Disseminated melanocarcinomatous of Lung and Brain ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Disseminated melanocarcinomatous of Lung and Brain (B) (C)		
19A. DATE OF OPERATION 2			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4/1, 1950, to 4/26, 1950, that I last saw the deceased alive on 4/26, 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.					
23A. SIGNATURE Leon E. Kanel M. D.		23B. ADDRESS Dumar Hospital		23C. DATE SIGNED 4/26/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-1950		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem.	
24D. LOCATION (City, town, or county) (State) North Ave. Balto Md.		25. FUNERAL DIRECTOR Thurston Williams, Inc.		25. ADDRESS 2435 E. Oliver St	
DATE RECEIVED BY LOCAL REGISTRAR		APR 28 1950			

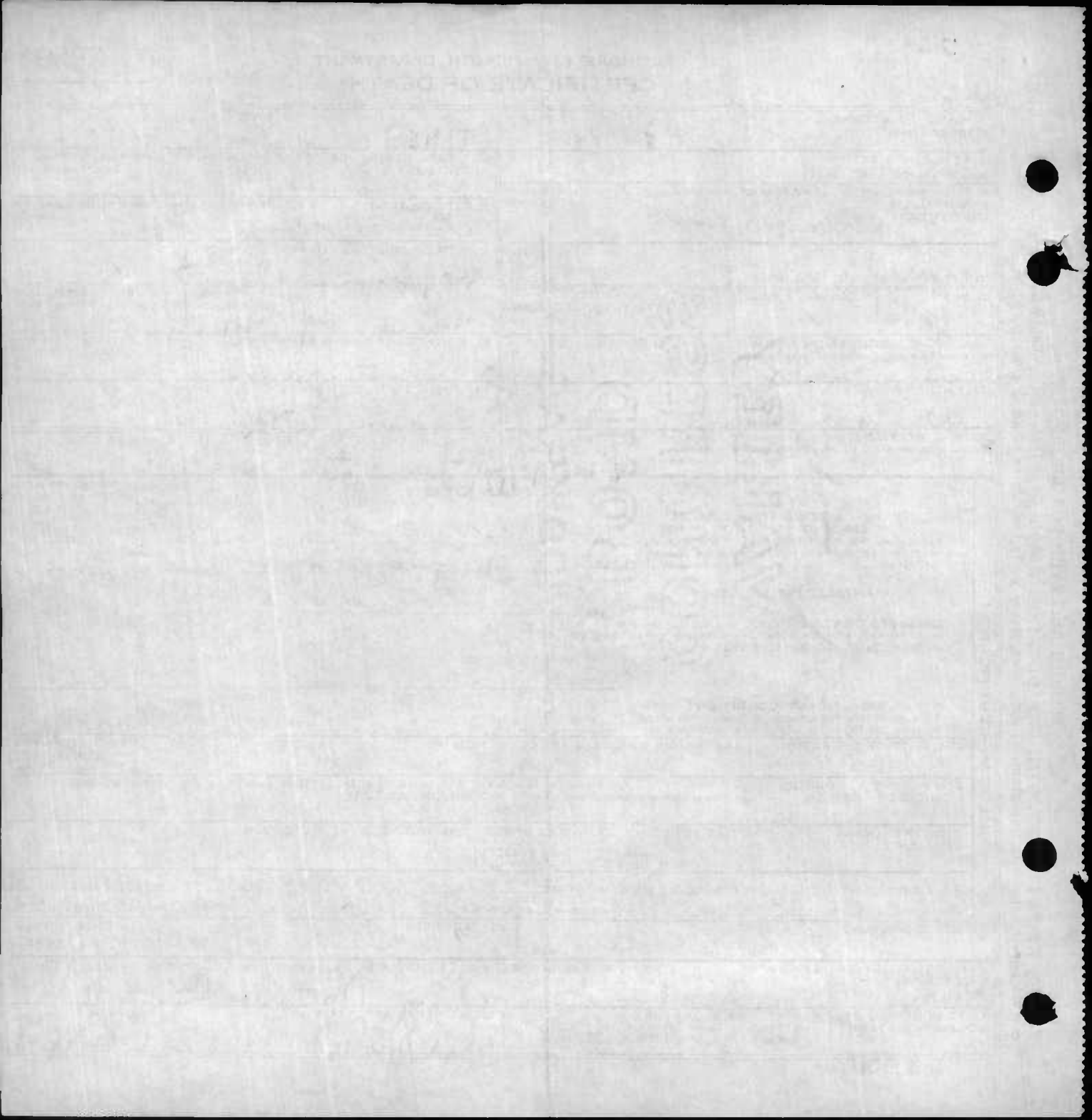
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

71071

477







PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H-634 CERTIFICATE CORRECTED

54-50

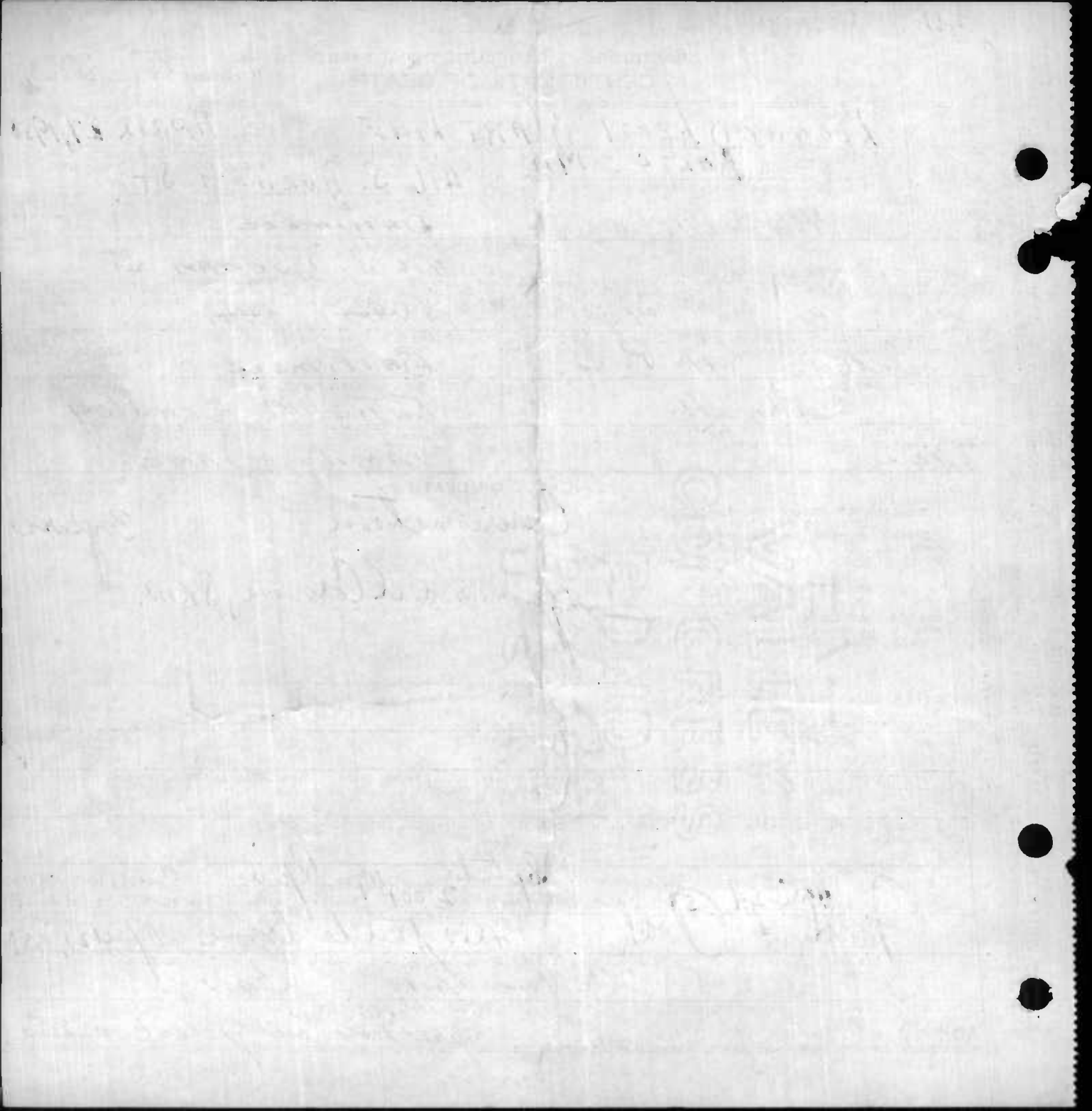
50 3931

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3931

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LEONARD HERBY HARTLINE</b>		2. DATE OF DEATH <b>APRIL 27, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>BALTO., MD.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ST.</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>00 416 S. DURHAM ST</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 2-02</b>			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>416 S. Durham St.</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>		8. DATE OF BIRTH <b>3-8-1904</b>	9. AGE (in years, last birthday) <b>45 (46)</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dattel.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Av. P. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>John H.</b>		14. MOTHER'S MAIDEN NAME <b>Katie M. Bradley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>FAMILY - SAME.</b>	

18. <b>191 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Carcinomatosis</b> (A) DUE TO <b>Squamous cell Carcinoma, SKIN.</b> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
<p>II</p> <p>19. ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>September 1949</b> to <b>April 1950</b> , that I last saw the deceased alive on <b>April 27, 1950</b> , and that death occurred at <b>2:00 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>John F. Cook</b>		23B. ADDRESS <b>4200 Shields Avenue</b>	
23C. DATE SIGNED <b>April 27, 1950</b>		23D. SIGNATURE <b>John F. Cook</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>5-8-50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 28 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. L. Williams</b>	
25. FUNERAL DIRECTOR <b>James L. Casey</b>		ADDRESS <b>130 E. Fairview</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3932

BIRTH NO. 50 3932			1. NAME OF DECEASED (Type or Print) <i>Richard Steinberger</i>			2. DATE OF DEATH <i>Apr. 28, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Pa</i> B. COUNTY <i>V-35</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Gettysburg</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			D. STREET ADDRESS (If rural, give location) <i>132 Carlisle St</i>			E. Length of stay in Baltimore Yrs. Mos. Days		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>8-7-36</i>	9. AGE (In years last birthday) <i>13</i>	If Under 1 Year Months: Days	If Under 24 Hours Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <i>Gettysburg Pa.</i>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>Robert F. Steinberger</i>			14. MOTHER'S MAIDEN NAME <i>Viola Storm</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS		

18. <i>239X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Teratoma - mediastinum</i>			CAUSE OF DEATH <i>Teratoma - mediastinum</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO			CERTIFICATION APPROVED BY <i>Dr. Wm. G. Helfrich</i> <i>R. B. Fisher</i> M.D. CHIEF OR ASST. MEDICAL EXAMINER		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Operative excision of tumor</i>								
19A. DATE OF OPERATION <i>4/26/50</i>			19B. MAJOR FINDINGS OF OPERATION <i>Large Teratoma involving mediastinum &amp; both pleural cavities</i>			20. AUTOPSY		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>4/23, 1950</i> to <i>4/28, 1950</i> , that I last saw the deceased alive on <i>4/28, 1950</i> and that death occurred at <i>11:24</i> m., from the causes and on the date stated above.								
23A. SIGNATURE <i>Gordon Malone Carver</i> M.D.			23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			23C. DATE SIGNED		
24A. BURIAL, CREMATION, REMOVAL (Specify)			24B. DATE <i>5-1-50</i>			24C. NAME OF CEMETERY OR CREMATORY <i>St. Ignace Cem.</i>		
24D. LOCATION (City, town, or county) (State) <i>Gettysburg, Pa</i>			25. FUNERAL DIRECTOR <i>Schmuneck Funeral Home Inc</i> <i>2601 E Madison St. 56E</i> <i>Charles E. Schmuneck</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 28 1950</i>			REGISTRAR'S SIGNATURE <i>Wm. J. Williams</i>					

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3933  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **ANDREW HENRY PUSKAR (GUNNER)**2. DATE  
OF DEATH **April 26, 1950**3. PLACE OF DEATH:  
A. Baltimore City, Maryland **910 S. Kenwood Ave.**4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE **Md.** B. COUNTY before admission)B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
**Baltimore** township)D. STREET ADDRESS (If rural, give location)  
**910 S. Kenwood Ave.**

c. Length of stay in Baltimore

5. SEX

**male**

6. COLOR OR RACE

**white**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
**widowed**Yrs.  
Mos.  
Days

8. DATE OF BIRTH

**Jan. 6, 1886**9. AGE (In years  
last birthday)**64**If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)**carpenter**10B. KIND OF BUSINESS OR  
INDUSTRY**Spedden Ship Build. Co.**

11. BIRTHPLACE (State or foreign country)

**Czechoslovakia**12. CITIZEN OF  
WHAT COUNTRY?  
**U.S.**

13. FATHER'S NAME

**unknown**

14. MOTHER'S MAIDEN NAME

**unknown**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
**no**16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

**Edw. F. Puskar, 910 S. Kenwood Ave.**18. **241X**

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)(A) **Acute myocardial infarction of a  
chronic myocardiopathy****Sudden  
5 yr.**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) **Chronic bronchial asthma with  
emphysema****20 yr.**(C) **Arteriosclerosis****5 yr.**II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from **Feb. 1940** to **Apr. 26, 1950**, that I last saw the  
deceased alive on **Mar 31, 1950**, and that death occurred at **9:45 p.m.** from the causes and on the date stated above.

23A. SIGNATURE

**Geo. A. Jeffery**

M. D.

23B. ADDRESS

**426 S. Calverton Park Ave.**

23C. DATE SIGNED

**4/28/50**24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)**Burial**

24B. DATE

**May 1, 1950**

24C. NAME OF CEMETERY OR CREMATORY

**Holy Redeemer Cem.**

24D. LOCATION (City, town, or county)

**4430 Belair Rd. Balto. Md.**

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Thurston Williams**

25. FUNERAL DIRECTOR

ADDRESS

**Schimunek Funeral Home, Inc.  
2601-345 E. Madison St.**



NOT A MEDICAL EXAMINER'S CASE  
Chester J. Lubinski, M.D.

per

*[Signature]*

M.D.

CHIEF OR ASS'T. MEDICAL EXAMINER



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3934243  
50 3934

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Emma B. Hughlett</u>		2. DATE OF DEATH <u>4/27/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>514 N. East A ve.</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md. Balto</u> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>00</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>26-10</u>	
c. Length of stay in Baltimore <u>60 Yrs</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>514 N. East Ave.</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Dec 15, 1885</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife at home</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>64</u>
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernard Rezek</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Marie R. Lowenstein, 1409 Peabody Ave, Tenn.</u>		ADDRESS <u>Memphis</u>	

18. 157XDISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Carcinoma of Pancreas  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

About 18 mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)   
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)   
DUE TO19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1950, to April 28, 1950, that I last saw the deceased alive on April 1, 1950, and that death occurred at 6 A m., from the causes and on the date stated above.

23A. SIGNATURE

John A. Cooley

M. D.

23B. ADDRESS

Johns Hopkins Hospital

23C. DATE SIGNED

4-28-5024A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial24B. DATE  
5/1/5024C. NAME OF CEMETERY OR CREMATORY  
Oak Hill24D. LOCATION (City, town, or county) (State)  
Horners Lane

DATE RECEIVED BY LOCAL REGISTRAR

APR 28 1950

REGISTRAR'S SIGNATURE

Wm. H. Williams, Jr.

25. FUNERAL DIRECTOR

Schimmack Funeral Home, INC  
2601-05-05 E. Madison St.

ADDRESS

Charles E. Schimmack  
469

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
OFFICE OF THE COMMISSIONER  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Occupation		10. Education		11. Marital Status		12. Date of Marriage	
13. Name of Physician		14. Name of Funeral Home		15. Name of Undertaker		16. Name of Burial Place	
17. Name of Coroner		18. Name of Medical Examiner		19. Name of Pathologist		20. Name of Anatomist	
21. Name of Registrar		22. Name of Clerk		23. Name of Stenographer		24. Name of Typewriter	
25. Name of Messenger		26. Name of Driver		27. Name of Porter		28. Name of Janitor	
29. Name of Cook		30. Name of Nurse		31. Name of Doctor		32. Name of Surgeon	
33. Name of Dentist		34. Name of Pharmacist		35. Name of Optician		36. Name of Electrician	
37. Name of Plumber		38. Name of Carpenter		39. Name of Painter		40. Name of Bricklayer	
41. Name of Blacksmith		42. Name of Tailor		43. Name of Shoemaker		44. Name of Hatter	
45. Name of Barber		46. Name of Beautician		47. Name of Hairdresser		48. Name of Dressmaker	
49. Name of Seamstress		50. Name of Tailor		51. Name of Shoemaker		52. Name of Hatter	
53. Name of Barber		54. Name of Beautician		55. Name of Hairdresser		56. Name of Dressmaker	
57. Name of Seamstress		58. Name of Tailor		59. Name of Shoemaker		60. Name of Hatter	
61. Name of Barber		62. Name of Beautician		63. Name of Hairdresser		64. Name of Dressmaker	
65. Name of Seamstress		66. Name of Tailor		67. Name of Shoemaker		68. Name of Hatter	
69. Name of Barber		70. Name of Beautician		71. Name of Hairdresser		72. Name of Dressmaker	
73. Name of Seamstress		74. Name of Tailor		75. Name of Shoemaker		76. Name of Hatter	
77. Name of Barber		78. Name of Beautician		79. Name of Hairdresser		80. Name of Dressmaker	
81. Name of Seamstress		82. Name of Tailor		83. Name of Shoemaker		84. Name of Hatter	
85. Name of Barber		86. Name of Beautician		87. Name of Hairdresser		88. Name of Dressmaker	
89. Name of Seamstress		90. Name of Tailor		91. Name of Shoemaker		92. Name of Hatter	
93. Name of Barber		94. Name of Beautician		95. Name of Hairdresser		96. Name of Dressmaker	
97. Name of Seamstress		98. Name of Tailor		99. Name of Shoemaker		100. Name of Hatter	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

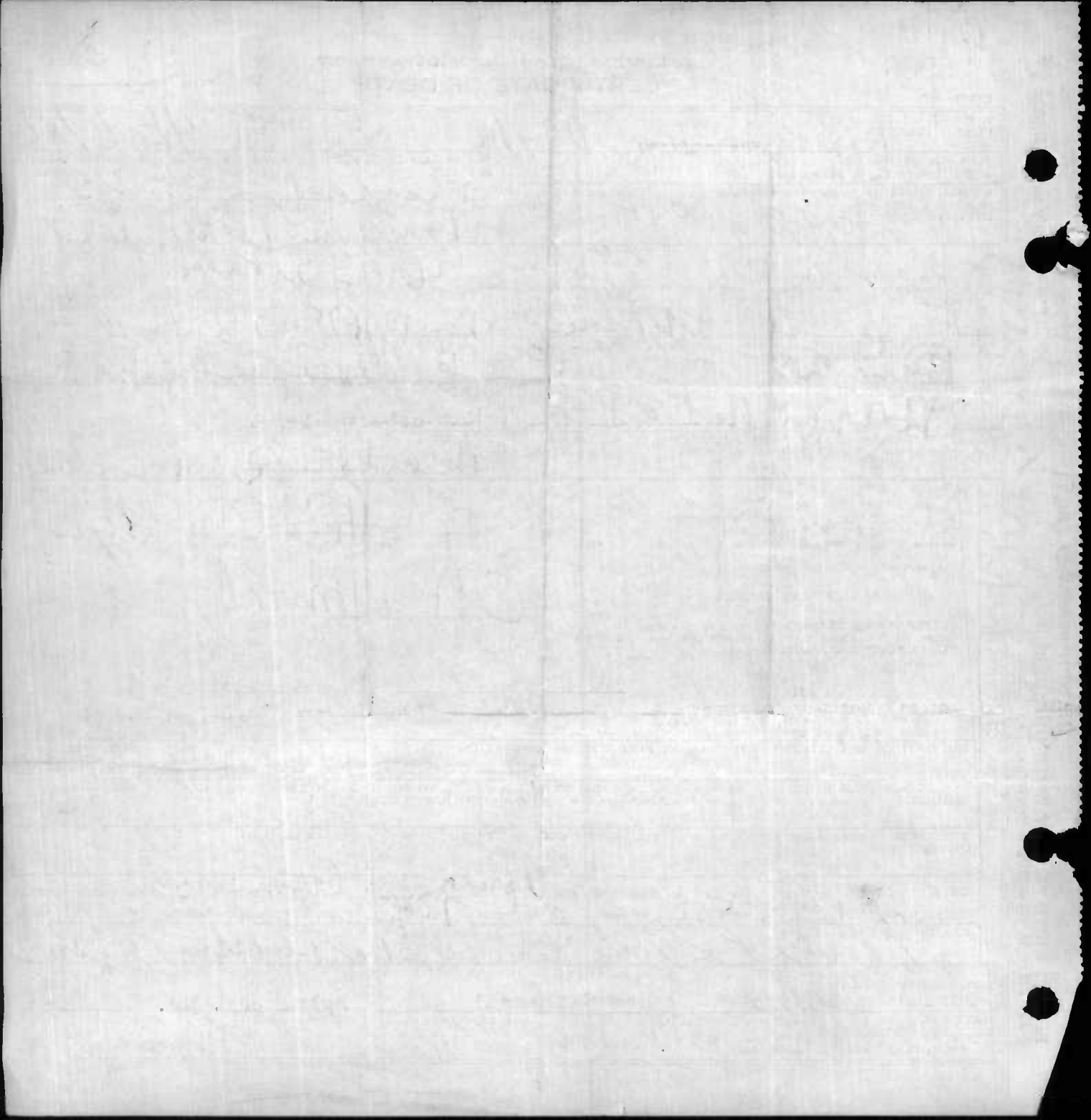
 Registered No. 50 3935

BIRTH NO. <u>50 3935</u>		1. NAME OF DECEASED (Type or Print) <u>George Ruark</u>		2. DATE OF DEATH <u>4/26/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>4-02</u>			
c. Length of stay in Baltimore <u>75 yrs</u>		D. STREET ADDRESS (If rural, give location) <u>653 W. Lexington St</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-17-1865</u>	9. AGE (In years last birthday) <u>84</u>	10. Under 1 Year Months: <u>0</u> Days: <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>La Plata, Md.</u>	
13. FATHER'S NAME <u>George Ruark</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Lillian M. Lennon</u>	
18. <u>4221</u>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Arteriosclerotic C.V.D. - heart</u>			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <u>P. L. Lumb</u>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		23C. DATE SIGNED <u>4/26/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-29-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. FUNERAL DIRECTOR <u>Frank A. Cole</u>		24F. ADDRESS <u>1913 W. Baltimore St.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 28 1950</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
DEATH CERTIFICATE

1904







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3937**BIRTH NO. **50-28345**1. NAME OF DECEASED  
(Type or Print)

Baby Jones

2. DATE  
OF  
DEATH

2-21-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

University Hospital

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

Baltimore 23

D. STREET ADDRESS (If rural, give location)

232 N. Carlton St.

18-02

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
baby

8. DATE OF BIRTH

2-21-50

9. AGE (In years  
last birthday)If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

2

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Alfred Johnson

14. MOTHER'S MAIDEN NAME

Delores Costello Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

mother-232 N. Carlton St.

18.

762.5  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH(A) Aspiration asphyxia  
DUE TO Labor premature

2 hrs

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-21-50, 19, to 2-21-50, 19, that I last saw the  
deceased alive on 2-21-50, 19, and that death occurred at 10.50A from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

City disposal

ADDRESS

Replaced for. Aerial Stillbirth Certificate  
# 36325 . 4/28/50 - Grange

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3938

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bessie Eakens

2. DATE  
OF  
DEATH

Apr. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Oak 5

4. USUAL RESIDENCE (Where deceased lived, If institution, residence

A. STATE

Va.

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

2608 N. Powhatan St

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3-20-12

9. AGE (In years  
last birthday)

38

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

227X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Myxoma of the heart

3 mo.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/27, 1950 to 4/28, 1950, that I last saw the  
deceased alive on 4/28, 1950, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

David L. Bessie

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4-28-1950

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Washington D.C.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 28 1950

Huntington Williams, M.D.

J. S. Sewler, Son, Washington  
J. S. Sewler, Son, 56 E D.C.

Myron = a. Turner copy of numerous leaves.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3939  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Alexander Castagnetti</b>		2. DATE OF DEATH <b>April 26, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1019 S. Hanover St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b>	
c. Length of stay in Baltimore <b>37 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>1019 S. Hanover St.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 15, 1865</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>merchant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>produce</b>	9. AGE (In years last birthday) <b>84 yrs</b>
11. BIRTHPLACE (State or foreign country) <b>Pisa Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pasquale Castagnetti</b>		14. MOTHER'S MAIDEN NAME <b>Ermelinda Palamidessi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Andred Castagnetti</b>		ADDRESS <b>1009 Hanover St.</b>	

18. **4/22/1**

**CAUSE OF DEATH**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial degeneration**  
DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arteriosclerosis**  
DUE TO

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 1950</b> to <b>April 26, 1950</b> , that I last saw the deceased alive on <b>4/26/50</b> , and that death occurred at <b>2:59 p.m.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Denis J. McGrath</b>		23B. ADDRESS <b>1 E. Randall St.</b>		23C. DATE SIGNED <b>4/28/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 29/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Belair Rd. Balto. Md.</b>		25. FUNERAL DIRECTOR <b>KRAUSE, FUNERAL HOME</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 29 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		ADDRESS <b>1216 S. Charles Balto. 30</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of burial place		18. Signature of interment		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment	
25. Signature of burial place		26. Signature of interment		27. Signature of burial place		28. Signature of interment	
29. Signature of burial place		30. Signature of interment		31. Signature of burial place		32. Signature of interment	
33. Signature of burial place		34. Signature of interment		35. Signature of burial place		36. Signature of interment	
37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment	
45. Signature of burial place		46. Signature of interment		47. Signature of burial place		48. Signature of interment	
49. Signature of burial place		50. Signature of interment		51. Signature of burial place		52. Signature of interment	
53. Signature of burial place		54. Signature of interment		55. Signature of burial place		56. Signature of interment	
57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment	
65. Signature of burial place		66. Signature of interment		67. Signature of burial place		68. Signature of interment	
69. Signature of burial place		70. Signature of interment		71. Signature of burial place		72. Signature of interment	
73. Signature of burial place		74. Signature of interment		75. Signature of burial place		76. Signature of interment	
77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment	
85. Signature of burial place		86. Signature of interment		87. Signature of burial place		88. Signature of interment	
89. Signature of burial place		90. Signature of interment		91. Signature of burial place		92. Signature of interment	
93. Signature of burial place		94. Signature of interment		95. Signature of burial place		96. Signature of interment	
97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 3940

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

BARBARA WAITZ

2. DATE  
OF  
DEATH

Apr. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

407 N. Ellwood Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
407 N. Ellwood Ave.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widow

8. DATE OF BIRTH

Apr. 26, 1869

9. AGE (In years last birthday)

71

10. Under 1 Year 11. Under 24 Hours  
Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Housewife

10B. KIND OF BUSINESS OR INDUSTRY  
At home

11. BIRTHPLACE (State or foreign country)  
Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Roth

14. MOTHER'S MAIDEN NAME  
Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Eleanor Roth, Glencoe, Md.

18.

CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

1/2 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

Coronary Disease

Arterio-Sclerosis

Unknown

Unknown

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 3, 1950, to April 27, 1950, that I last saw the deceased alive on April 27, 1950, and that death occurred at 12:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Philip Artigiani

23B. ADDRESS

2942 E. Fayette St.

23C. DATE SIGNED

4/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county) (State)

Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

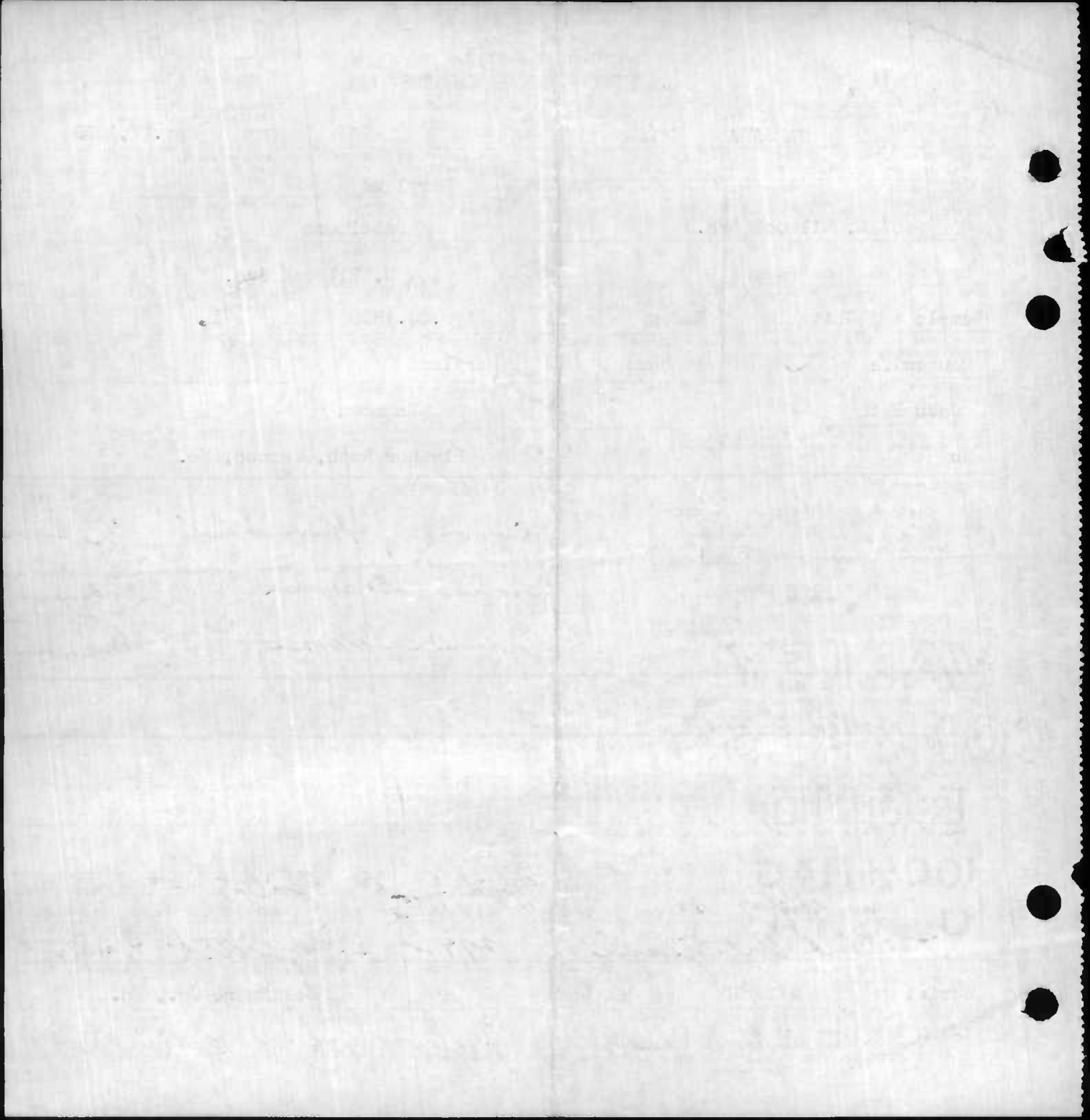
William P. P. 1219 5th Ave

VS 150

94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3941

Registered No.

BIRTH NO. 3941

1. NAME OF DECEASED  
(Type or Print)

Freida B. Stubel

2. DATE  
OF  
DEATH

April 27/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE

Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

909 S. Potomac St.

C. CITY OR TOWN

If outside corporate limits, write RURAL and give township)

Balto.

1-01

D. STREET ADDRESS (If rural, give location)

909 S. Potomac St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

June 16-1882

9. AGE (In years

last birthday)

67

11. Under 1 Year

Months: Days

12. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August Noble

14. MOTHER'S MAIDEN NAME

Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Minnie Redmond 4219 Patterson PK An.

ADDRESS

18.

153X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of Colon

DUE TO

Metastasis Liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Acute Cholelithiasis

DUE TO

Acute Transient Emaciation

(C)

INTERVAL BETWEEN ONSET AND DEATH

2.

6 mos.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Feb 10-50

19B. MAJOR FINDINGS OF OPERATION

Grossly enlarged Metastasis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10-50, 1950, to April 27, 1950, that I last saw the deceased alive on April 27, 1950, and that death occurred at 11:00 m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. G. G. G.

23B. ADDRESS

156 N. E. E. E.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

April 29-50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

APR 29 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John A. Miller

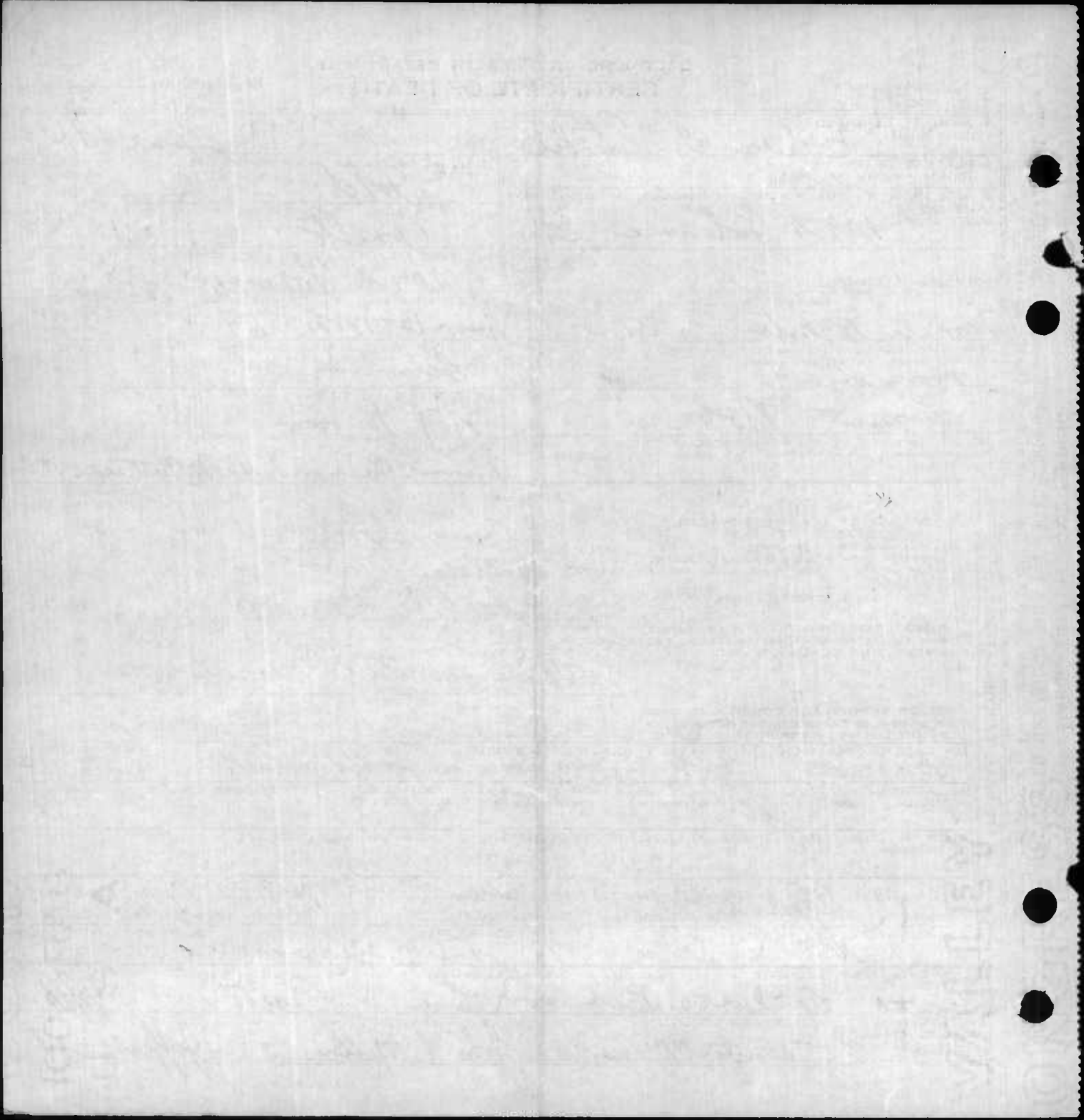
ADDRESS

2334 Jefferson St.

VS 150

46E

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 3942

1. NAME OF DECEASED  
(Type or Print)

LUKE W. HENDERSON

2. DATE  
OF  
DEATH

April 26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland *St Agnes*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE *3 Maple Drive* B. COUNTY *Baltimore* (before admission)B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)*St Agnes Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Patterson Md 5200*

D. STREET ADDRESS (If rural, give location)

*3 Maple Drive*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Married*

B. DATE OF BIRTH

*Sept 30*9. AGE (in years  
last birthday)*76*11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Tool maker*10B. KIND OF BUSINESS OR  
INDUSTRY*Retired*

11. BIRTHPLACE (State or foreign country)

*Conn.*12. CITIZEN OF  
WHAT COUNTRY?*US*

13. FATHER'S NAME

*David Henderson*

14. MOTHER'S MAIDEN NAME

*Mary A. White*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)*Yes*16. SOCIAL  
SECURITY NO.

17. INFORMANT

*Mid South Henderson*

ADDRESS

18. *4/27/50*

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *MASSIVE CEREBRAL*DUE TO *HEMORRHAGE*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *ARTERIO-SCLEROTIC CARDIO*DUE TO *VASCULAR DISEASE -*(C) 

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

*4/27/50*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4/27, 1950* to *4/27, 1950* that I last saw the deceased alive on *4/27, 1950* and that death occurred at *4:50 P.M.* from the causes and on the date stated above.

23A. SIGNATURE

*John H. Shaw*

M. D.

23B. ADDRESS

*St. Agnes Hosp.*

23C. DATE SIGNED

*4/27/50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*May 1/1950*

24C. NAME OF CEMETERY OR CREMATORY

*Restland*

24D. LOCATION (City, town, or county)

*Huntington Conn*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR*APR 29 1950*

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

*Max Hest - Schv.*

ADDRESS

Oct 6582



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3943

BIRTH NO. \_\_\_\_\_

JL\* -135559

1. NAME OF DECEASED  
(Type or Print)

Carrie Louise Holmes

2. DATE  
OF  
DEATH

4-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

16-03

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

812 N. Bruce St.

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Sep.

8. DATE OF BIRTH

Nov. 15, 1925

9. AGE (In years last birthday)

24

H Under 1 Year Months: Days

H Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M d.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Charles W. Gassaway

14. MOTHER'S MAIDEN NAME

Louise Coates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18.

002X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pulmonary tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cardiac failure

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2-6-50, 19, to April 26, 1950, that I last saw the deceased alive on April 26, 1950, and that death occurred at 5.15am, from the causes and on the date stated above.

23A. SIGNATURE

*Dr. W. H. H. H.*

M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

4-26-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

APR 29 1950

Huntington Williams, M.D.

927. Mount Airy

Metropolitan Funeral Home Inc

STATE OF TEXAS  
COUNTY OF DALLAS

1914

Name of Deceased		Age		Sex		Color		Marital Status		Occupation		Cause of Death		Place of Death		Time of Death		Date of Death	
John Doe		35		Male		White		Single		Farmer		Heart Disease		Home		10:00 AM		April 15, 1914	
Father		Mother		Wife		Children		Siblings		Parents		Religion		Education		Social Status		Other	
John Doe		Jane Doe		Mary Doe		Robert Doe		William Doe		Elizabeth Doe		Protestant		High School		Middle Class		None	
Born		Died		Buried		Interment		Funeral		Burial		Cremation		Other		Remarks		Signature	
April 10, 1879		April 15, 1914		April 15, 1914		April 15, 1914		April 15, 1914		April 15, 1914		April 15, 1914		April 15, 1914		April 15, 1914		John Doe	

Witness my hand and seal this 15th day of April, 1914.

Notary Public for the State of Texas

John Doe

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3944  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Elizabeth

SMITH

2. DATE  
OF DEATH April 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Westport

D. STREET ADDRESS (If rural, give location)

2611 Hollinsberry Road

c. Length of stay in Baltimore

22 Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 15, 1903

9. AGE (In years last birthday)

46

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTH PLACE (State or foreign country)

Indiana

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Mary Nevilles

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Wiley E. Smith 2611 Hollinsberry Road

18. E914.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Asphyxia due to electrocution

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2611 Hollinsberry Rd., Westport, Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

April 27, 1950 ? P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Short circuit through decedent from defective vacuum cleaner to furnace grill

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

April 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

APR 29 1950

REGISTRAR'S SIGNATURE

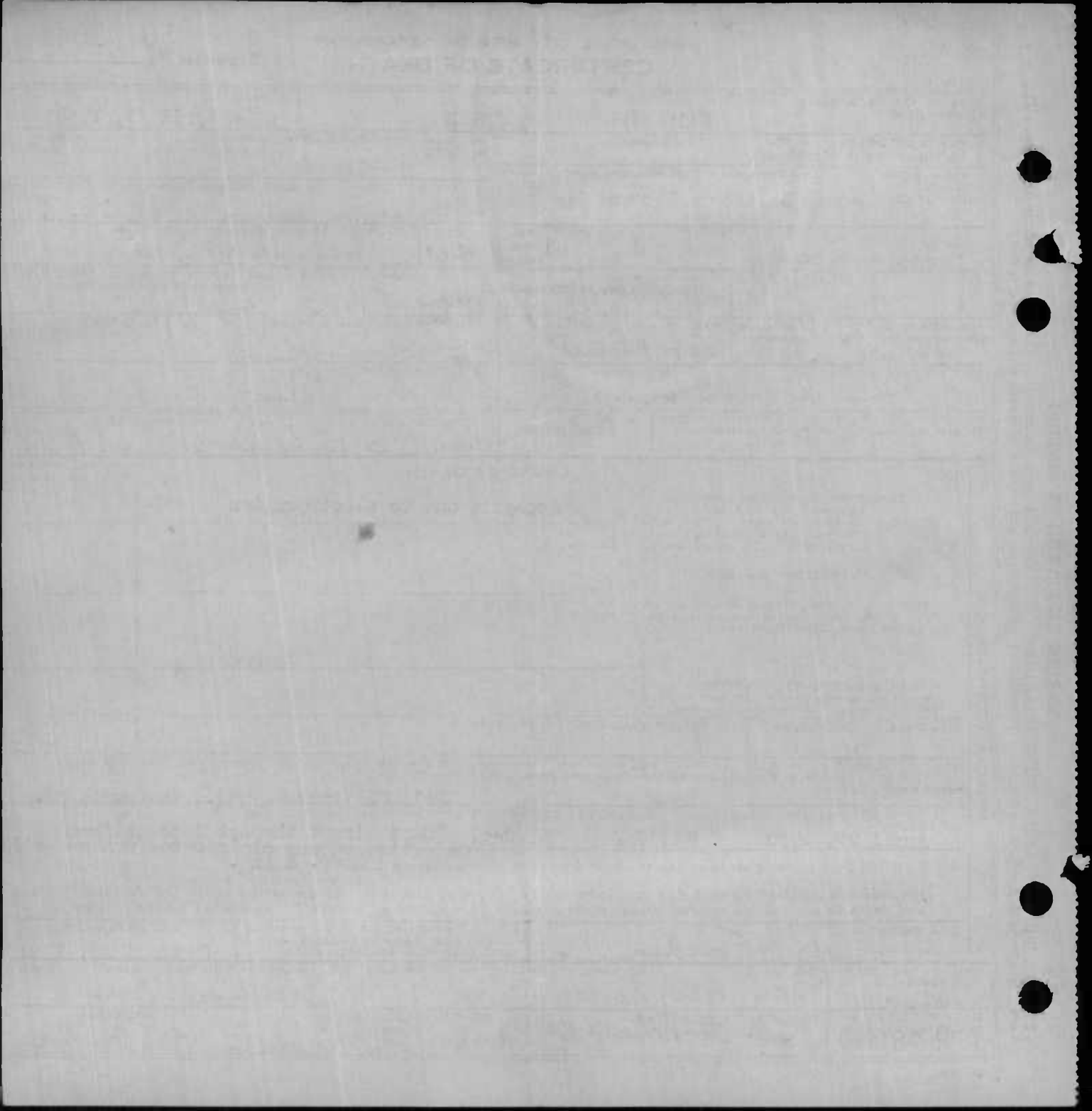
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Arthur W. Guefel &amp; Son 5311 Edmondson

ADDRESS

193 Cave



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3945  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOHN ARNOLD MURPHY</b>			2. DATE OF DEATH <b>4/26/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>622 Bartlett Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 9-08</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>622 Bartlett Avenue</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1883</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plummer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Continental Imp. Co.- Baltimore, Md.</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <b>Tomothy S. Murphy</b>			14. MOTHER'S MAIDEN NAME <b>(?)</b>		
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Mrs. Marg. Murphy-622 Bartlett Avenue</b>		

18. <b>151X 1 002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH  (A) <b>Legate Cardiac Vascular</b> DUE TO <b>Decompensation</b>  (B) <b>Carcinoma of Stomach</b> DUE TO _____  (C) <b>Chronic Pulmonary Tuberculosis</b> DUE TO _____	INTERVAL BETWEEN ONSET AND DEATH  _____
---	--	---

**II**  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY  
**Dr. Lubinski**  
per **PS Fisher**

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		CHIEF OR <del>ASST.</del> MEDICAL EXAMINER <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/26, 1950</b> to <b>4/26, 1950</b> ; that I last saw the deceased alive on <b>P.O.A. 4/26/50</b> and that death occurred at <b>11 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Sigmund Goldberg</b> M. D.		23B. ADDRESS <b>1422 Park Ave</b>		23C. DATE SIGNED <b>4/28/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/1/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>	24D. LOCATION (City, town, or county) (State) <b>City</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 29 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>Wiedefeld &amp; Son, GREENMOUNT AVE &amp; 22ND</b>

\* See over. 348V9

**Wiedefeld & Son**  
**GREENMOUNT AVE & 22ND 46B**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Patient has been under the care of Dr. Frankel for months. Dr. Frankel was out of town, and Dr. Goldberg was caring for his practice and pronounced the man dead.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3946  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John O. Mitchell

2. DATE  
OF  
DEATH

April 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
MarylandB. COUNTY  
noneB. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

3811 St. Paul St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

c. Length of stay in Baltimore

62 Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3811 St. Paul St.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Dec. 21, 1873

9. AGE (In years  
last birthday)

76

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

funeral director

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Harford County, Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U. S.

13. FATHER'S NAME

John Parker Mitchell

14. MOTHER'S MAIDEN NAME

Mary Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mahlon B. Mitchell

ADDRESS

3811 St. Paul St.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

10 minutes

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Arterio-sclerosis  
Hypertension  
Myocarditis

DUE TO

Gradual

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 194, to April 28, 1950, that I last saw the  
deceased alive on 4-28, 1950, and that death occurred at 5:20 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. B. Ready

M. D.

23B. ADDRESS

1403 Park Ave.

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

5 - 1 - 50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.

ADDRESS

Mahlon B. Mitchell

UNITED STATES OF AMERICA  
DEPARTMENT OF COMMERCE  
BUREAU OF MARITIME SERVICE

1. Name of Vessel  
2. Type of Vessel  
3. Home Port  
4. Date of Departure  
5. Date of Arrival  
6. Name of Captain  
7. Name of Master  
8. Name of Pilot  
9. Name of Engineer  
10. Name of Steward  
11. Name of Cook  
12. Name of Cabin Boy  
13. Name of Deck Hand  
14. Name of Fireman  
15. Name of Stoker  
16. Name of Sailor  
17. Name of Apprentice  
18. Name of Boy  
19. Name of Girl  
20. Name of Child  
21. Name of Infant  
22. Name of Adult  
23. Name of Elderly  
24. Name of Young  
25. Name of Middle-aged  
26. Name of Old  
27. Name of Very Old  
28. Name of Very Young  
29. Name of Very Elderly  
30. Name of Very Middle-aged

31. Name of Very Young  
32. Name of Very Elderly  
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174. Name of Very Middle-aged  
175. Name of Very Young  
176. Name of Very Elderly  
177. Name of Very Middle-aged  
178. Name of Very Young  
179. Name of Very Elderly  
180. Name of Very Middle-aged

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

50 3947

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

CHARLES HYLAND HORNER

2. DATE  
OF  
DEATH

APR. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

3425 UNIVERSITY PLACE

C. CITY OR TOWN

BALTO.

(If outside corporate limits, write RURAL and give township)

12-02

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3425 UNIVERSITY PLACE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

OCT. 9, 1886

9. AGE (In years  
last birthday)

63

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

VICE PRES.

10B. KIND OF BUSINESS OR  
INDUSTRY

FURNITURE &amp; INT. DEC.

11. BIRTHPLACE (State or foreign country)

BALTO.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WILLIAM FRANK HORNER

14. MOTHER'S MAIDEN NAME

KATHERINE SHARRETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

212-03-3881

17. INFORMANT

MRS. C.H. HORNER

ADDRESS

SAME

18.

163X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma of the Lung

10 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Sept. 1949

19B. MAJOR FINDINGS OF OPERATION

Inoperable Carcinoma of the Lung

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 8, 1949, to April 26, 1950, that I last saw the deceased alive on April 24, 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Walter B. Allen M.D.

23B. ADDRESS

6 E. Zenger St.

23C. DATE SIGNED

4-27-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

5-1-1950

24C. NAME OF CEMETERY OR CREMATORY

NEW CATHEDRAL

24D. LOCATION (City, town, or county)

BALTO.

MO.

DATE RECEIVED BY  
LOCAL REGISTRAR

APR 29 1950

REGISTRAR'S SIGNATURE

Walter B. Allen

25. FUNERAL DIRECTOR

H.W. JENKINS &amp; Sons Co. 4905 YORK RD

ADDRESS

VS 150

15667

471

MARGIN RESERVED FOR PRINTING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. WARD ALLEN

G E EAGER - 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

552  
59 3948

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3948

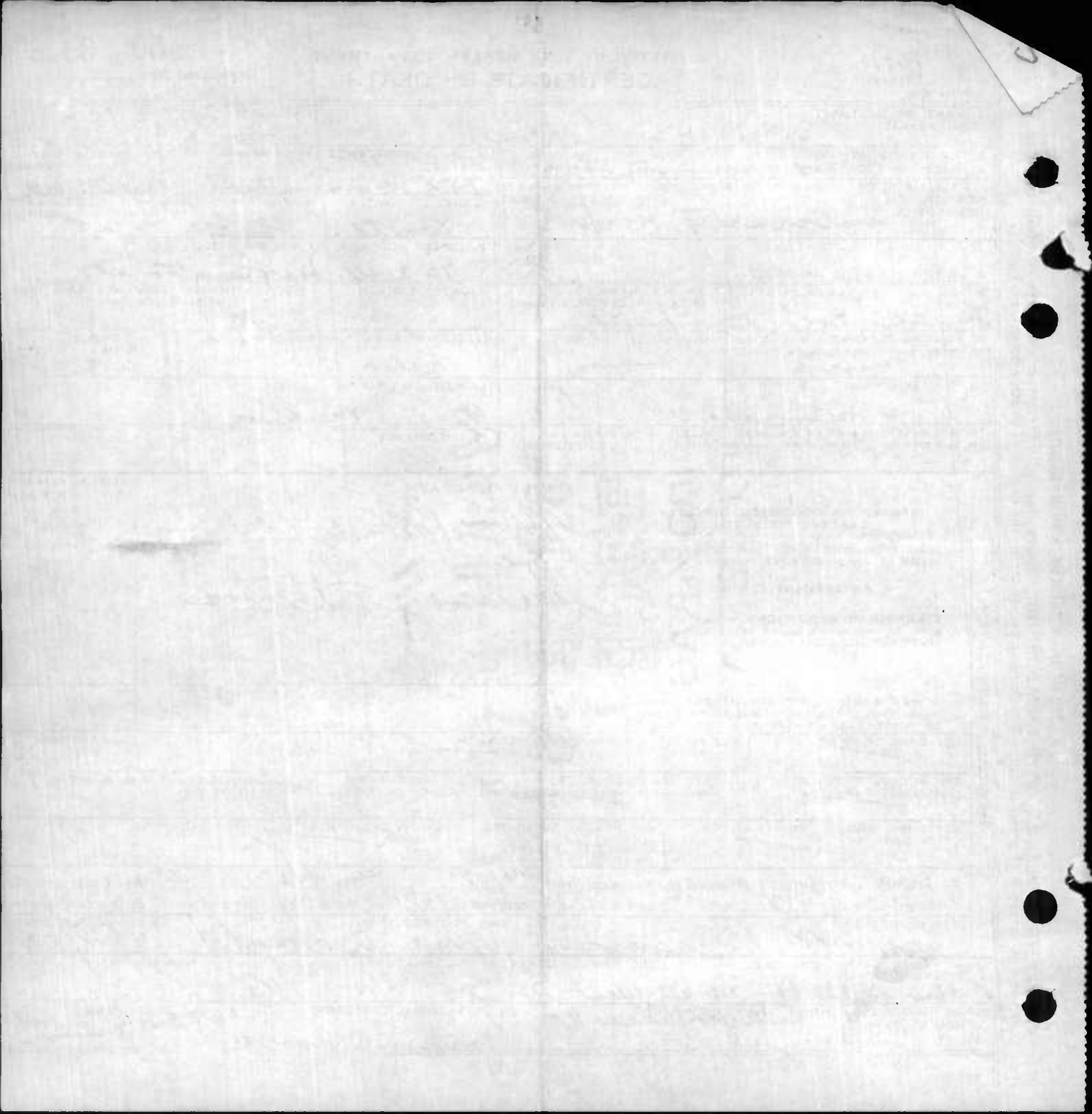
Registered No.

BIRTH NO.													
1. NAME OF DECEASED (Type or Print)							2. DATE OF DEATH						
SIMMONS, Carrie							4/27/50						
3. PLACE OF DEATH:							4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)						
a. Baltimore City, Maryland							a. STATE b. COUNTY						
b. FULL NAME OF (If not in hospital or institution, give street address or location)							752 W. Lexington St. Balto. Md.						
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)							Balto. 4-02						
c. Length of stay in Baltimore							o. STREET ADDRESS (If rural, give location)						
5. SEX							752 W. Lexington St.						
6. COLOR OR RACE			7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)				8. DATE OF BIRTH			9. AGE (In years last birthday)			
Female Colored			Single							30			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
none				none				Va			U.S.A.		
13. FATHER'S NAME							14. MOTHER'S MAIDEN NAME						
Wm Johnson							Bessie McKinney						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)							16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			

18. <u>002X</u>	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <u>Massive Pulmonary Hemorrhage</u> (A) _____ DUE TO <u>Pulmonary Tuberculosis</u> (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION _____	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in <u>Baltimore</u> City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>4/17</u> , 19 <u>50</u> , to <u>4/27</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4/27</u> , 19 <u>50</u> , and that death occurred at <u>10:38 P</u> m., from the causes and on the date stated above.			
23A. SIGNATURE <u>James M. Biseman</u> M. O.		23B. ADDRESS <u>University Hospital</u>	
23C. DATE SIGNED <u>4/28/50</u>		24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24B. DATE <u>4-29-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>West Point</u>	
24D. LOCATION (City, town, or county) <u>Va</u>		24E. ADDRESS _____	
DATE RECEIVED BY LOCAL REGISTRAR <u>APR 29 1950</u>		25. FUNERAL DIRECTOR <u>James A. Stayer</u>	

132







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3949  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edmund Joseph Johnson

2. DATE  
OF  
DEATH

April 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

18-01

D. STREET ADDRESS (If rural, give location)

868 W. Fayette St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 4, 1893

9. AGE (In years  
last birthday)

56 yrs.

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR  
INDUSTRY

Retail Commercial

11. BIRTHPLACE (State or foreign country)

Nasau

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph Johnson

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital record - Patient

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Occlusion

Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Hypertensive Cardiovascular Disease

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Prostatic hyperplasia - Diabetic Mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 24, 1950, to April 25, 1950, that I last saw the  
deceased alive on April 25, 1950, and that death occurred at 7:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

B. Han. J.

23B. ADDRESS

Provident Hospital

23C. DATE SIGNED

April 27, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

APR 29 1950

Tunington Williams, M.D.

Funeral Home

1641 Daniel Hill Ave.

RECEIVED THE OFFICE OF THE  
DEPARTMENT OF DEATH

RECEIVED THE OFFICE OF THE  
DEPARTMENT OF DEATH  
JAN 10 1964  
JAN 10 1964  
JAN 10 1964

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JAN 10 1964

RECEIVED THE OFFICE OF THE  
DEPARTMENT OF DEATH  
JAN 10 1964  
JAN 10 1964  
JAN 10 1964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully secured. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3950  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY E. BABYLON

2. DATE  
OF  
DEATH

4/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2012 Hollins St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto.

20-03

D. STREET ADDRESS (If rural, give location)

2012 Hollins St.

C. Length of stay in Baltimore

Lifetime

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb. 14 1886

9. AGE (In years, last birthday)

64

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mordecia W. Babylon

14. MOTHER'S MAIDEN NAME

Sarah E. Stoner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Francis Reese Westminister Md.

1B. 4/27/50

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

arterio-sclerotic  
cardio vascular disease

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

none

(C) DUE TO

none

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/5/50 to 4/27/50, 1950, that I last saw the deceased alive on 4/27/50, and that death occurred at 10 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin Miller

M. D.

23B. ADDRESS

1030 Wilkens Ave

23C. DATE SIGNED

4/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 1 1950

24C. NAME OF CEMETERY OR CREMATORY

Krider's Cem

24D. LOCATION (City, town, or county)

Westminister Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

Francis Reese

ADDRESS

Westminister Md. 93D

APR 29 1950

2030 WILKINS AVE.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3951

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ernest J. Newell

2. DATE  
OF  
DEATH

April 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-08A

D. STREET ADDRESS (If rural, give location)

3433 Mandamin Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9-19-86

9. AGE (In years last birthday)

63

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Auctioneer &amp; Real Estate Operator - (self)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Henry Newell

14. MOTHER'S MAIDEN NAME

Callie Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

-none

16. SOCIAL SECURITY NO.  
213-10-7069

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

162X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Broncho pneumonia

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Carcinoma of lung &amp;

DUE TO

(C)

intracranial metastases

&gt; 8 mos

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4-4, 1950, to 4-27, 1950 that I last saw the deceased alive on 4-27, 1950 and that death occurred at 940 pm., from the causes and on the date stated above.

23A. SIGNATURE

Ernest C Brown Jr

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

4/29/50

24C. NAME OF CEMETERY OR CREMATORY

-

24D. LOCATION (City, town, or county)

Norfolk, Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Dickens &amp; Sons

ADDRESS

Baltimore

APR 29 1950

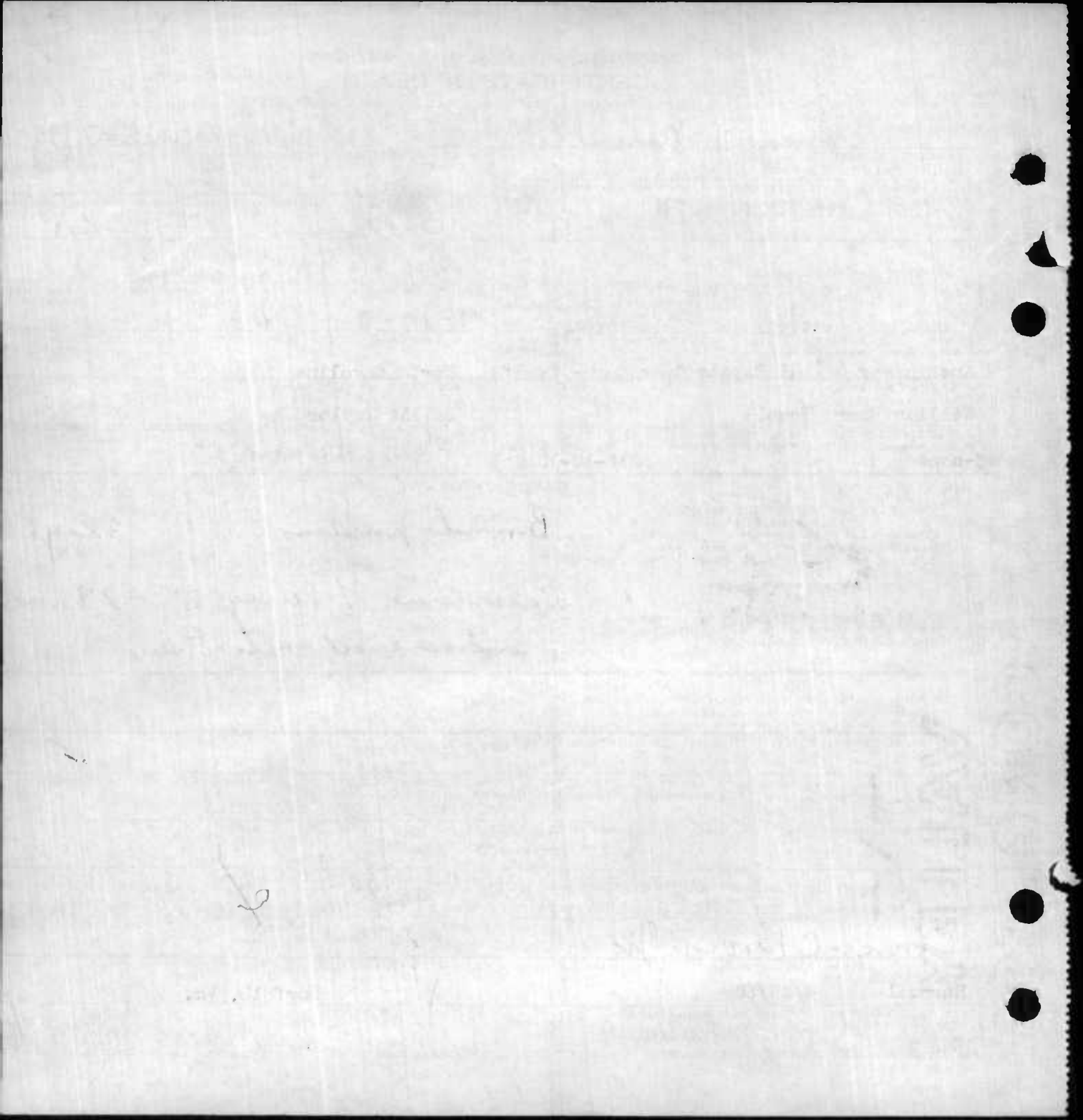
VS 150

276A1

477

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The color of age is especially important. Physicians: please write the causes of death clearly and legibly.





# Feuss

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 Registered No. 50 3952

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Alida Feuss.*2. DATE  
OF  
DEATH*4/27/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Baltimore Md*

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

*Md.*

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION*St Joseph's Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore 15-08 B*

D. STREET ADDRESS (If rural, give location)

*2223 Roslyn Ave.*

c. Length of stay in Baltimore

*82. Yrs.  
Mos.  
Days*

5. SEX

*Female*

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Widowed*

8. DATE OF BIRTH

*June 10, 1869*9. AGE (In years;  
last birthday)*80*11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)*Housewife*10B. KIND OF BUSINESS OR  
INDUSTRY*At Home*

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF  
WHAT COUNTRY?*American*

13. FATHER'S NAME

*James E. Hopper*

14. MOTHER'S MAIDEN NAME

*Unknown*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

*Daughter*

ADDRESS

*2223 Roslyn Ave*18. *420.0*

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

*Pulmonary Edema*

DUE TO

*Cardiac Failure*

(B)

DUE TO

(C)

*Acute sclerotic heart disease*INTERVAL BETWEEN  
ONSET AND DEATH*5 hrs.*

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *April 27, 1950* to *April 27, 1950*, that I last saw the  
deceased alive on *April 27, 1950*, and that death occurred at *10 P* m., from the causes and on the date stated above.

23A. SIGNATURE

*W. E. Choud*

M. D.

23B. ADDRESS

*11 E. Chase*

23C. DATE SIGNED

*4/27/50*24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)*Burial*

24B. DATE

*5/1/50*

24C. NAME OF CEMETERY OR CREMATORY

*Greenmount Cem.*

24D. LOCATION (City, town, or county)

*Balto.*

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

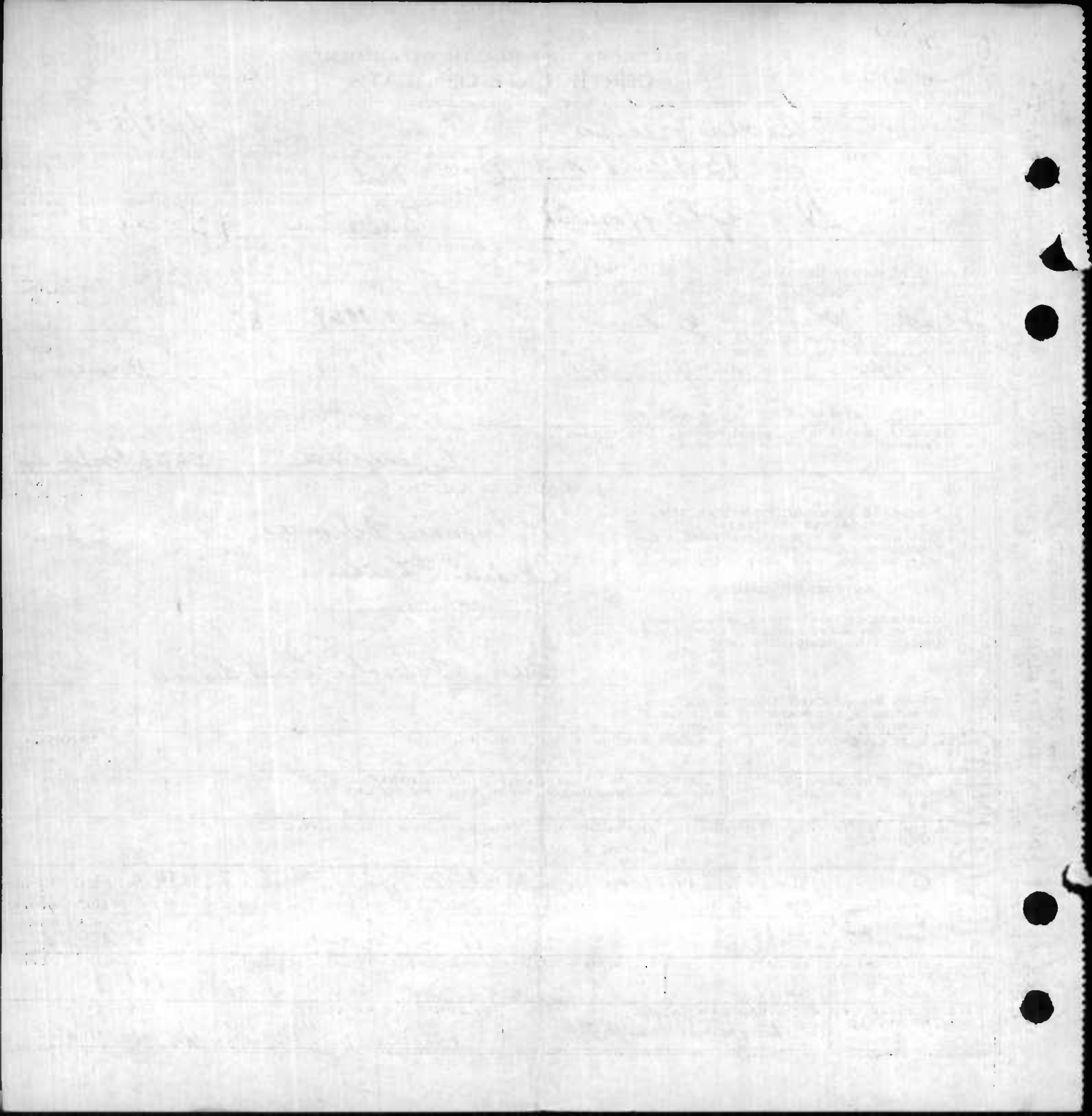
*W. Williams, J. Pickner & Sons - Balto.*

ADDRESS

*APR 29 1950*

VS 150

93D



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3953

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY A. YOUNG

2. DATE

OF

DEATH April 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto MdB. FULL NAME OF  
HOSPITAL OR  
INSTITUTION2908 Presstman St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2908 Presstman St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)married10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)Housewife10B. KIND OF BUSINESS OR  
INDUSTRYAt. Home

8. DATE OF BIRTH

Jan. 28, 18869. AGE (In years  
last birthday)64If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Hammel

14. MOTHER'S MAIDEN NAME

Mary --15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknowns) (If yes, give war or dates of service)no16. SOCIAL  
SECURITY NO.no

17. INFORMANT

ADDRESS

Mr. John W. Young, Jr. 2908 Presstman St18. 422.2DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

Myocarditis & Chronic  
nephritis  
Pulmonary Edema  
ascites

CERTIFICATION APPROVED BY

RBFisher M.D.INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

CHIEF OR ASST. MEDICAL EXAMINER.

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 31, 1950, to March 31, 1950, that I last saw the  
deceased alive on March 31, 1950, and that death occurred at 10a. m., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin Kadish 2306 Eutaw Pl

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial5/1/50Loudon Park Cem.Baltimore, Md.DATE RECEIVED BY  
LOCAL REGISTRAR

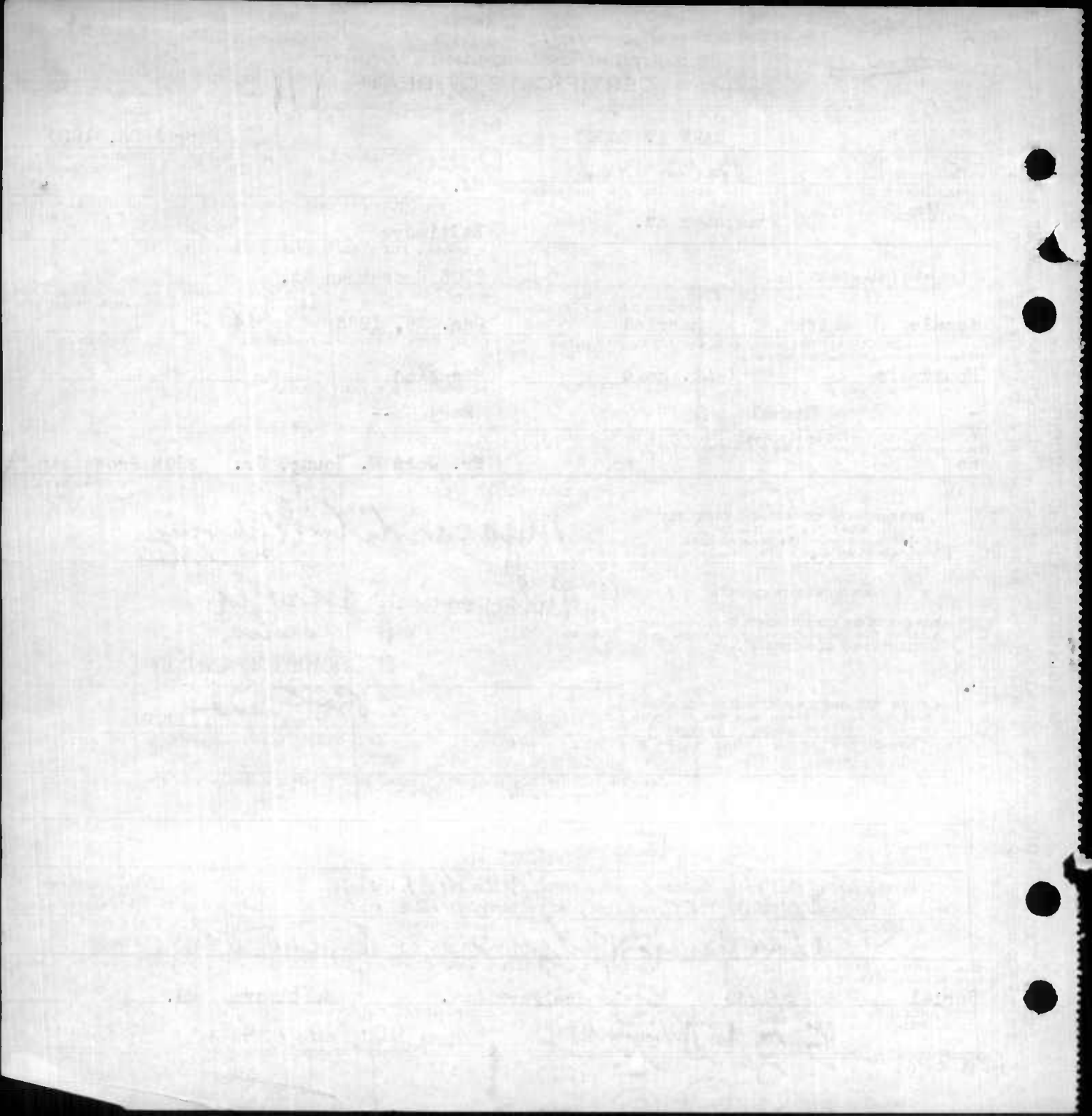
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Williams, M.D.Wm. J. Williams & Sons Balto Md.APR 29 1950  
150

131B



CERTIFICATE CORRECTED 5-9-50

552 50 3954

50 3954

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Henry Raymond Raymond Henry Sieminski</b>		2. DATE OF DEATH <b>April 28, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Penn.</b> B. COUNTY <b>V-25</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>CHILDRENS HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Montrose</b>	
C. LENGTH OF STAY IN BALTIMORE <b>1 mo.</b>		D. STREET ADDRESS (If rural, give location) <b>71 So. Main Street</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>12/7/25</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNERSHIP</b>		9. AGE (In years, last birthday) <b>24</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>	
13. FATHER'S NAME <b>Raymond J. SIEMINSKI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Stella MAJESKY</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>	

18. <b>08/10</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Primary Bronchial Obstruction</b>		8 min
ANTECEDENT CAUSES		(B) <b>aspiration of mucus</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) <b>Pneumonia, extensive, respiratory and peripheral</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Apr 5</b> , 1950, to <b>Apr 28</b> , 1950, that I last saw the deceased alive on <b>Apr 28</b> , 1950, and that death occurred at <b>11:10</b> p.m., from the causes and on the date stated above.				
23A. SIGNATURE <b>Nephi K. Kezerian</b>	23B. ADDRESS <b>Childrens Hospital School</b>	23C. DATE SIGNED <b>Apr 28 '50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>4/29/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>-</b>	24D. LOCATION (City, town, or county) (State) <b>Montrose, Pa.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 29 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	25. FUNERAL DIRECTOR <b>Wm. J. Pickens &amp; Sons</b>		

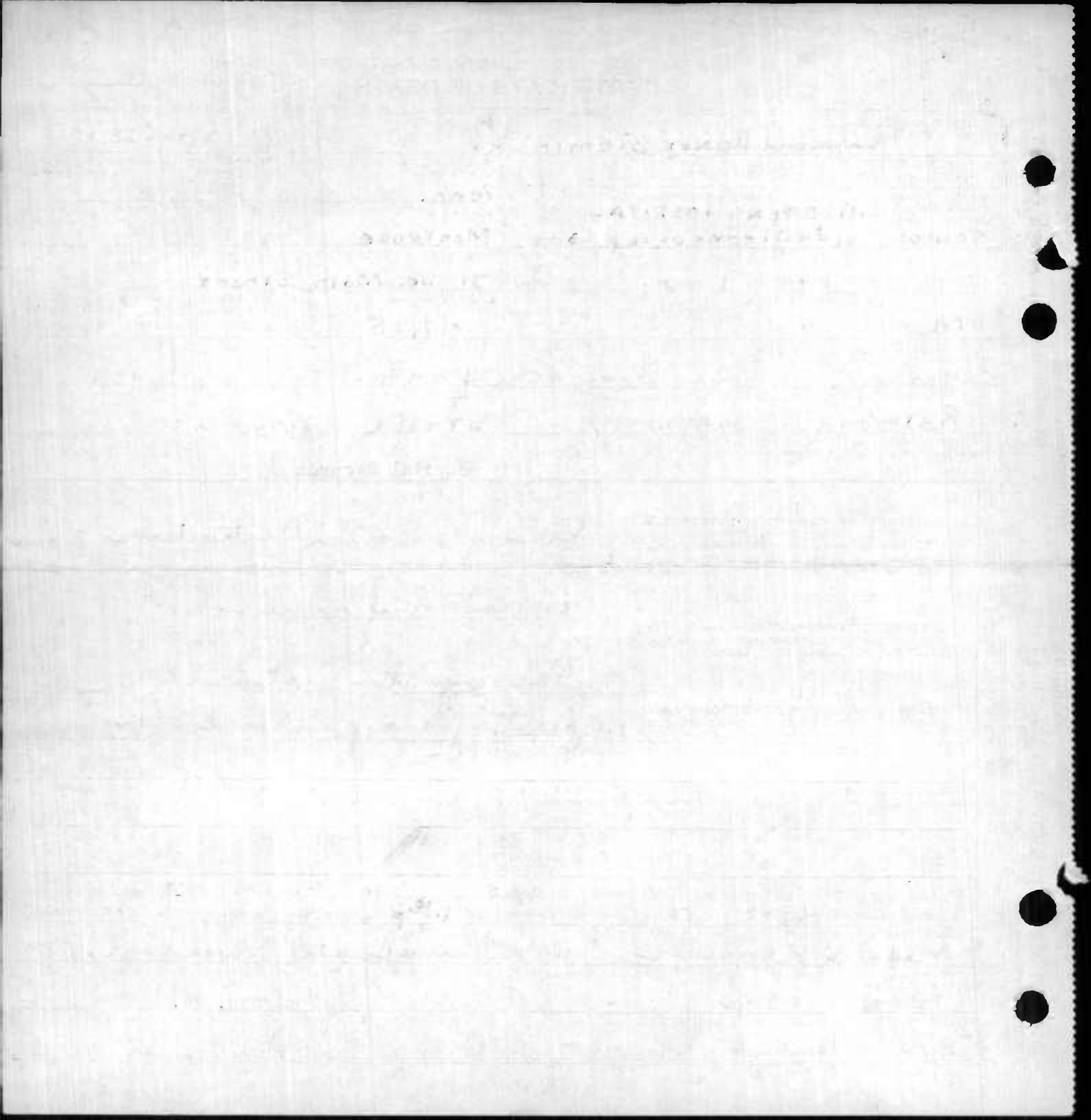
VS 150

15665

36 Balt Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully stated and legibly. Physicians: please write the causes of death clearly and legibly.

613  
M M 135815  
50 3955

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3955  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George, Griffith,

2. DATE  
OF  
DEATH

April 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals.

31 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 22-02

D. STREET ADDRESS (If rural, give location)  
Homeless - 828 Chinna St

C. Length of stay in Baltimore

23 Years

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 23, 1898

9. AGE (in years last birthday)

51

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unemployed LABORER

10B. KIND OF BUSINESS OR INDUSTRY

ODD JOBS

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Griffith

14. MOTHER'S MAIDEN NAME

Janie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
B.C.H. Records 4940 Eastern Ave

18.

002X I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-15, 19 50 to 4-27, 19 50 that I last saw the deceased alive on 4-27-50, 19 and that death occurred at 12:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS  
4940 Eastern Ave.

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/29/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Franklin Williams, M.D.

25. FUNERAL DIRECTOR

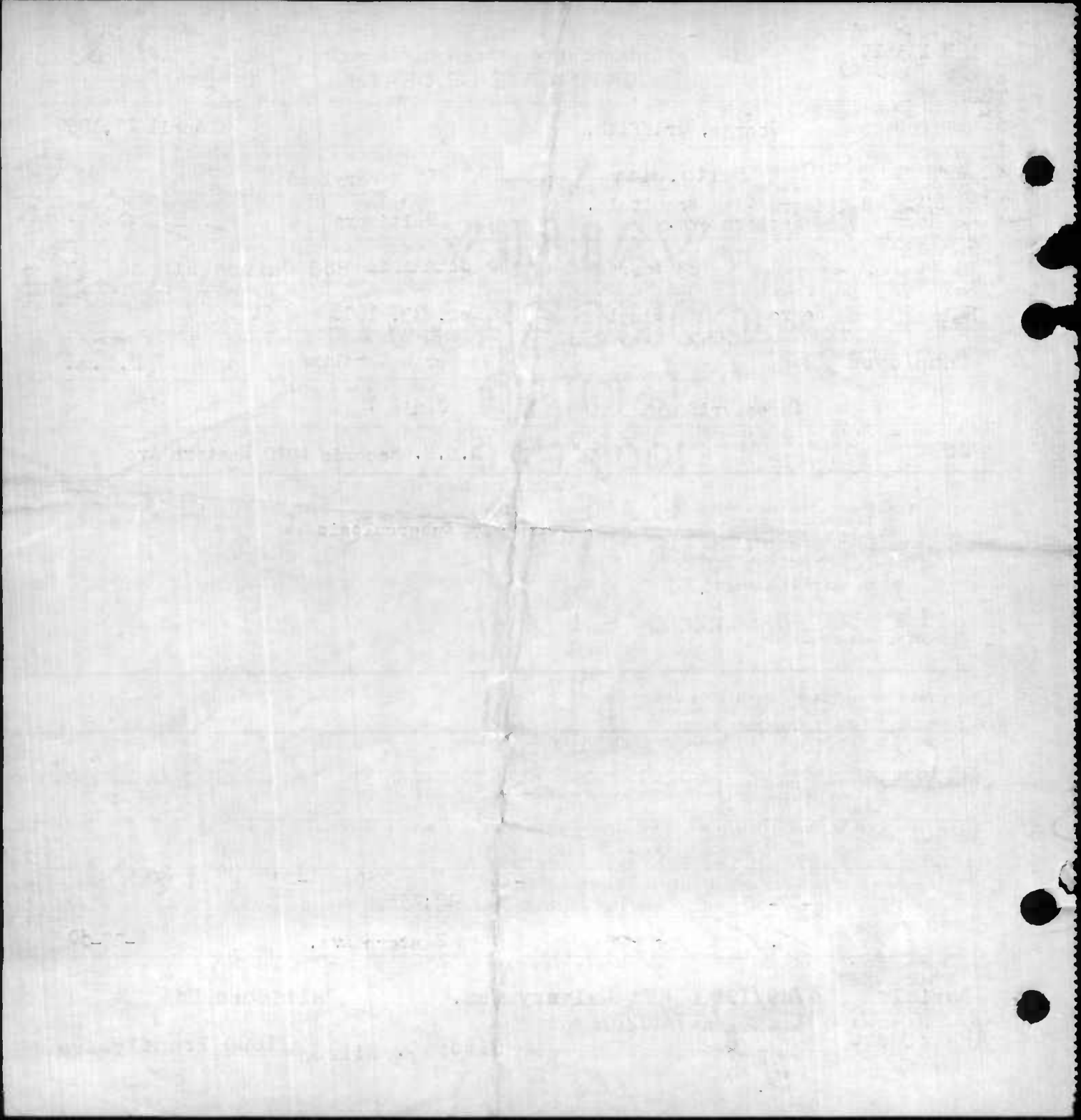
ADDRESS

Elroy O. Wilson 1000 Brantly Ave

VS 150

98899

1313



V-524

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3956

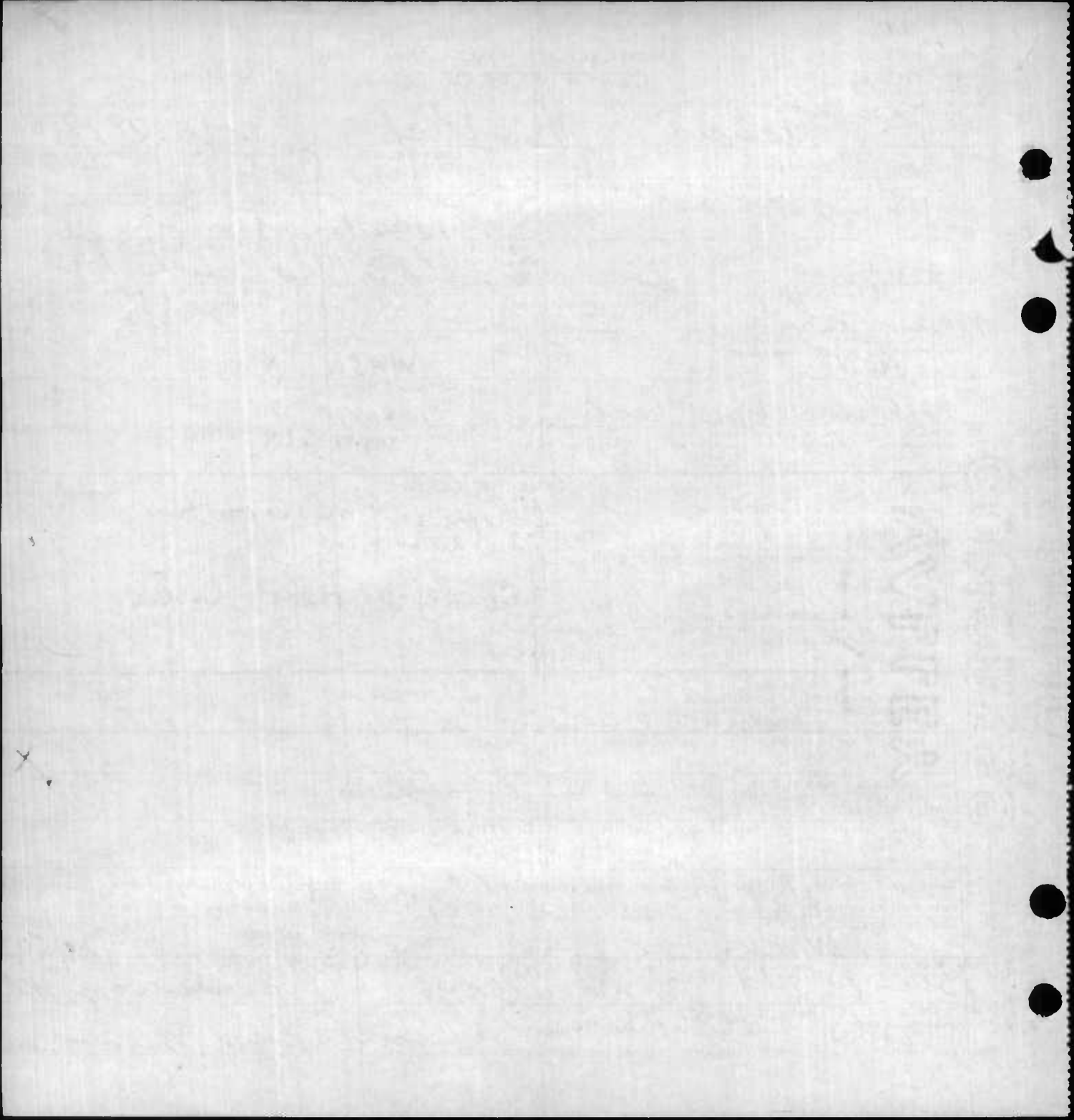
BIRTH NO. 50 3956

1. NAME OF DECEASED (Type or Print) <i>Richard L. Van Cleef</i>		2. DATE OF DEATH <i>Apr. 28, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>D.C.</i> B. COUNTY <i>N-48</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Washington 29</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		O. STREET ADDRESS (If rural, give location) <i>6123 Oaklawn Dr.</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>1-31-50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>2 1/2</i>
11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William Van Cleef</i>		14. MOTHER'S MAIDEN NAME <i>VIRGINIA J.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>754.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Pneumonitis</i> <i>Malnutrition</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/26</i> 1950, to <i>4/28</i> 1950, that I last saw the deceased alive on <i>4/28</i> 1950, and that death occurred at <i>7:00</i> P.M., from the causes and on the date stated above.					
23A. SIGNATURE <i>W. R. H. H. H.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>4/29/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>5/1/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		24E. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		24F. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>APR 29 1950</i>		REGISTRAR'S SIGNATURE <i>W. R. H. H. H.</i>		25. FUNERAL DIRECTOR <i>Hunt &amp; Ryan, Wadsworth, Md.</i>	
VS 150				157E	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3957

C-640  
50 3957  
41-65441

BIRTH NO. 41-65441

1. NAME OF DECEASED (Type or Print) Thomas Robert Carroll

2. DATE OF DEATH 4-28-50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY Anne Arundel

5. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION Union Memorial Hosp.

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Eastport 5200

7. STREET ADDRESS (If rural, give location)  
1203 Mc Kinley St.

8. LENGTH OF STAY IN BALTIMORE  
Yrs. 0 Mos. 0 Days 0

9. SEX m 10. COLOR OR RACE w 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single

12. DATE OF BIRTH 12-19-46 13. AGE (In years, last birthday) 3 14. Under 1 Year: Months 0 Days 0 15. Under 24 Hours: Hours 0 Min. 0

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 17. KIND OF BUSINESS OR INDUSTRY Child 18. BIRTHPLACE (State or foreign country) Maryland 19. CITIZEN OF WHAT COUNTRY? USA

20. FATHER'S NAME Charles R. Carroll 21. MOTHER'S MAIDEN NAME Margaret Muckley

22. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no 23. SOCIAL SECURITY NO. NO

24. INFORMANT ADDRESS NO

18. 204.4 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Anemia

ANTECEDENT CAUSES (B) Leukemia

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) NO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION no 19B. MAJOR FINDINGS OF OPERATION no 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) no 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) no 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY no 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? no

22. I hereby certify that I attended the deceased from 4-27 1950, to 4-28, 1950, that I last saw the deceased alive on 4-28, 1950, and that death occurred at 3:05 P. M., from the causes and on the date stated above.

23A. SIGNATURE William H. Stengel M. D. 23B. ADDRESS Union Memorial Hosp. 23C. DATE SIGNED 4-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal 24B. DATE April 29/50 24C. NAME OF CEMETERY OR CREMATORY Sandy Valley 24D. LOCATION (City, town, or county) (State) Waynesburg Ohio

DATE RECEIVED BY LOCAL REGISTRAR APR 30 1950 REGISTRAR'S SIGNATURE William H. Stengel 25. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 2008 Calver

VS 150

742

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of church		22. Signature of school		23. Signature of business		24. Signature of other	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	



N-200  
50 3958

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3958

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MR. ROBERT NASE</b>		2. OATE OF DEATH <b>4-29-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>V-35</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>BON SECOURS HOSPT.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>TRUMB AVERS VILLE</b>			
c. Length of stay in Baltimore <b>3 days</b>		D. STREET ADDRESS (If rural, give location) <b>—</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. OATE OF BIRTH <b>1881</b>	9. AGE (In years last birthday) <b>68</b>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>W.M. Moyer Co.</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
13. FATHER'S NAME <b>William Nase</b>		14. MOTHER'S MAIOMEN NAME <b>UNKNOWN.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>HAROLD BLONDIN 6402 WARDEN MILL RD.</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction</b> DUE TO ANTECEDEENT CAUSES <b>Coronary artery disease</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONOITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT. DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>					
19A. OATE OF OPERATION <b>4-20-50</b>		19B. MAJOR FINOINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-29</b> , 19 <b>50</b> , to <b>4-29</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-29</b> , 19 <b>50</b> , and that death occurred at <b>9:25 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>H. J. Mc Clafferty</b>		23B. ADDRESS <b>1114 St Paul St.</b>		23C. DATE SIGNED <b>4-29-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>4/29/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Ridge Valley</b>	
24D. LOCATION (City, town, or county) (State) <b>Bucks Co. PENNA.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Harry H. Witzke 4101 Edmondson Ave</b>			

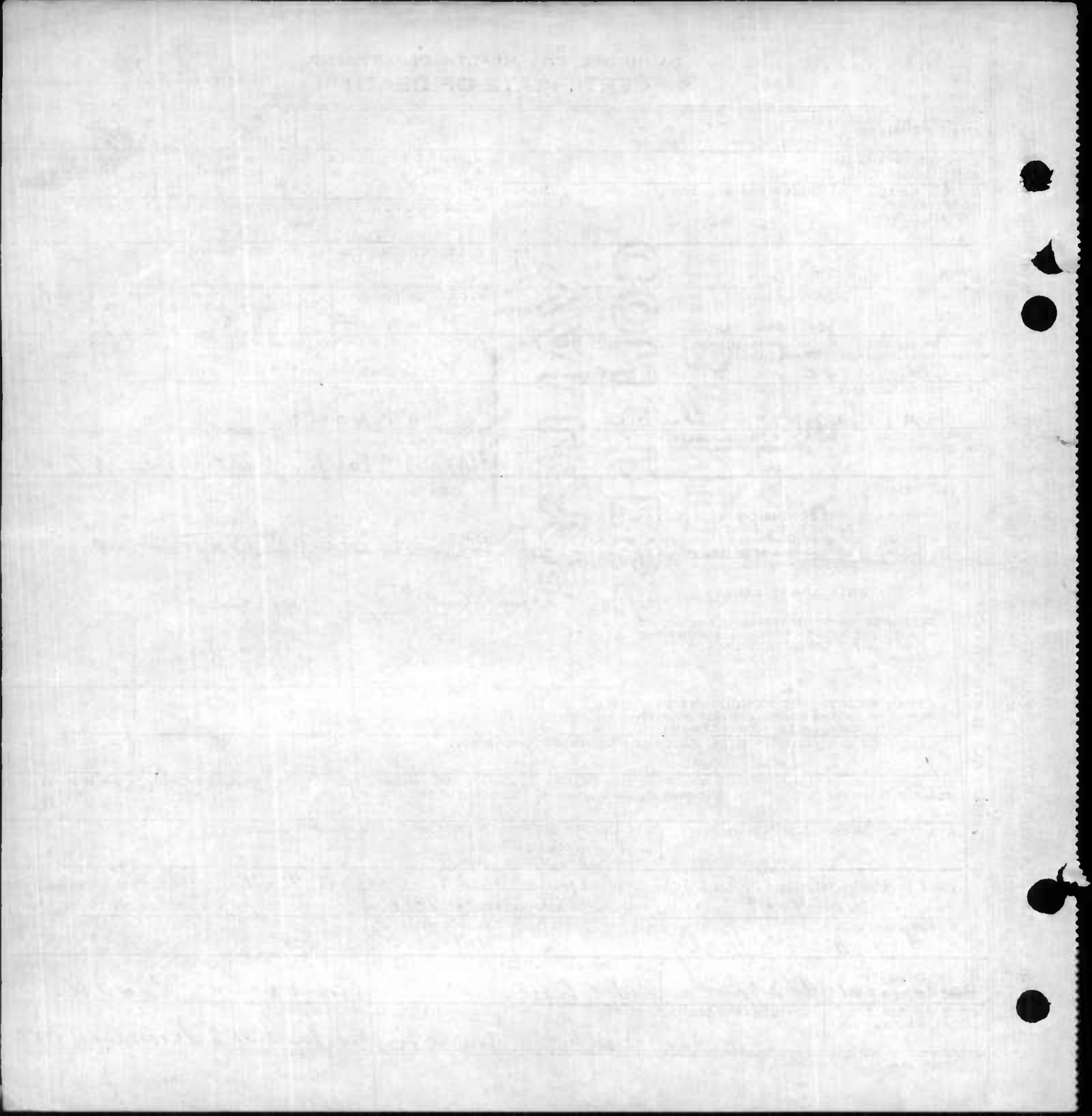
APR 30 1950

308 V9

94a

MARGIN RESERVED FOR BINDING  
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3959  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emma Martz

2. DATE  
OF  
DEATH

April 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 21-02

D. STREET ADDRESS (If rural, give location)

1223 JAMES ST.

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

B. DATE OF BIRTH

July 7, 1891

9. AGE (In years last birthday)

58

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John J. Iitter

14. MOTHER'S MAIDEN NAME

Eva Novak

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

ADDRESS

JR. R. MARTZ, JR. 1151 SARGENT ST.

18. 443X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Hypertensive Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, Jr.

23B. CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

April 29, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

5-2-50

24C. NAME OF CEMETERY OR CREMATORY

Meadowridge Memorial

24D. LOCATION (City, town, or county)

Howard County Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Kammer, Jr.

25. FUNERAL DIRECTOR

Geo. L. Schwab 2101 Frederick Ave

ADDRESS



C-462  
50 3960BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3960

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JEAN MARIE CLARK

2. DATE  
OF  
DEATH

APRIL 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

WICOMICO

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

PITTSVILLE

7200

D. STREET ADDRESS (If rural, give location)

P.O. BOX 17

c. Length of stay in Baltimore

21

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

APRIL 19, 1950

9. AGE (In years  
last birthday)

1

10. Under 1 Year  
Months Days

6

10

11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR  
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

HUBERT RUSSO CLARK

14. MOTHER'S MAIDEN NAME

BERENICE RICHARDSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL  
SECURITY NO.

—

17. INFORMANT

PARENTS

ADDRESS

PITTSVILLE, MD

18. 019.2 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) TUBERCULOUS MENINGITIS

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

4 WKS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) MILIARY TUBERCULOSIS

DUE TO

4 MOS

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 8, 1950, to April 29, 1950, that I last saw the  
deceased alive on April 29, 1950, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Thorne Amberg

M. D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

April 29, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

May 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

Pittsville Cemetery

24D. LOCATION (City, town, or county)

Pittsville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

T. W. Williams, M.D.

25. FUNERAL DIRECTOR

Holloway &amp; Co. Salisbury Md.

ADDRESS

VS 150  
APR 30 1950

13B

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL



S-160  
ES-137515BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3961  
Registered No.

BIRTH NO. 50 3961

1. NAME OF DECEASED  
(Type or Print)

Merlyn Shapito

2. DATE  
OF  
DEATH

4-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

Md

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

31 Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Rosewood State Training School

c. Length of stay in Baltimore

?

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

May 26, 1930

9. AGE (In years  
last birthday)

19

11 Under 1 Year  
Months: Days

11

11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Shapito

14. MOTHER'S MAIDEN NAME

Anna Abramson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS 4940  
Records\* Balto. City Hospitals Eastern Ave.

18. 753.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Tuberculous Sclerosis with increased Intracranial  
Pressure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4-25-50

19B. MAJOR FINDINGS OF OPERATION

Cerebral Biopsy

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-23 19 50 to 4-28 19 50, that I last saw the  
deceased alive on 4-28 19 50 and that death occurred at 6:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

R. B. Cohen M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4/30/50

24C. NAME OF CEMETERY OR CREMATORY

Har Zion Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

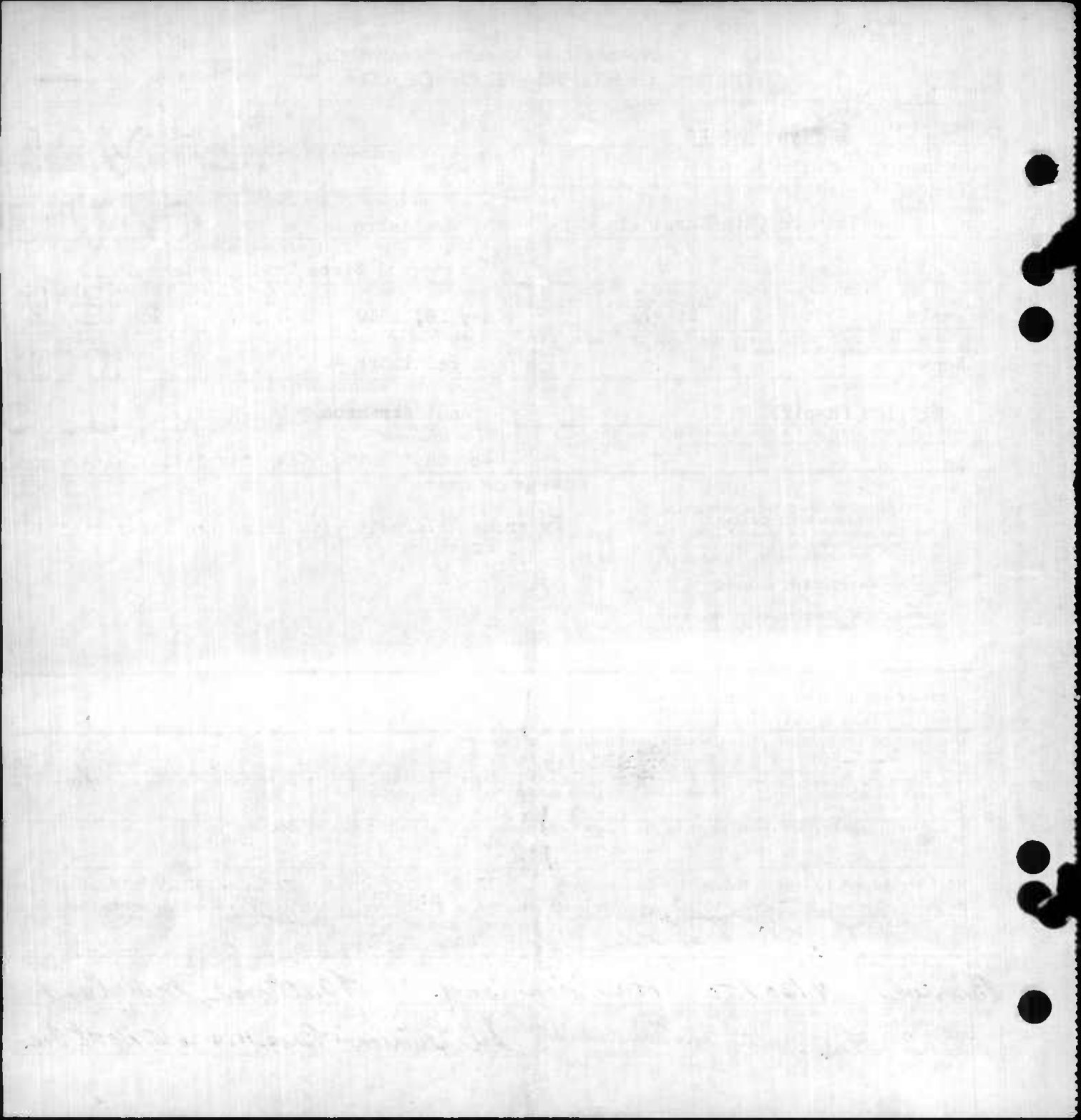
REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Sal. L. Linton + Bros. 1124-26 W. North Ave.



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. 50-08563

1. NAME OF DECEASED  
(Type or Print)

Baby O'FERRALL (1st twin)

2. DATE  
OF  
DEATH

4/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

MARYLAND

BALTIMORE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

15-10

D. STREET ADDRESS (If rural, give location)

3886 Sequoia Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

HOSPITAL FOR the

WOMEN OF MARYLAND

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

4/29/50

9. AGE (In years last birthday)

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

15 39

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Patrick O'FERRALL

14. MOTHER'S MAIDEN NAME

Agnes thelma Boesl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mother

3886 Sequoia Ave  
BALTIMORE MD.18. 774X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

ANOXIA

ANTECEDENT CAUSES

(B) DUE TO

Prematurity

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

15 hrs. 39. min

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from APRIL 28, 1950 to APRIL 29, 1950 that I last saw the deceased alive on APRIL 29, 1950, and that death occurred at 3:30 A. m., from the causes and on the date stated above.

23A. SIGNATURE

John C. Savage M. D.

23B. ADDRESS

6 E. Read St. Bldg. 2

23C. DATE SIGNED

APRIL 29 '50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

PR 30 1950

Livingston Williams, M.D.

19. 20. Meade and Son 805 N. Calver St.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

REPORT OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible] SEX: [illegible]  
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]

0-164  
50

3963

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

3963

Registered No.

BIRTH NO. 50-08564

1. NAME OF DECEASED  
(Type or Print)

Baby O'FERRALL (2nd twin)

2. DATE  
OF  
DEATH

4/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

HOSPITAL FOR the  
47 WOMEN OF MARYLAND

MARYLAND

BALTIMORE

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

13-10

D. STREET ADDRESS (If rural, give location)

3816 Sequoia Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

4/28/50

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

15 33

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Patrick O'FERRALL

14. MOTHER'S MAIDEN NAME

Agnes thelma Boesl

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

3816 Sequoia Ave  
BALTIMORE MARYLAND

Mother

18. 774X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

ANOXIA

DUE TO

ANTECEDENT CAUSES

(B)

Prematurity

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

05h 39 min

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APRIL 28, 1950 to APRIL 28, 1950, that I last saw the  
deceased alive on APRIL 28, 1950, and that death occurred at 5:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

John E. Savage

M. D.

23B. ADDRESS

66. Read St. Bk. 2

23C. DATE SIGNED

APRIL 28, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Huntington Williams, M.D.

26. W. M. M. and Son 505 N. Calvert St.

APR 30 1950

159

MARGIN RESERVED FOR BINDING  
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

County of Cook, State of Illinois

Decem 1904

Attest

My Comm. Expires

Notary Public

in and for the State of Illinois

My Comm. Expires

Notary Public

in and for the State of Illinois

My Comm. Expires

Notary Public

in and for the State of Illinois

My Comm. Expires

Notary Public

in and for the State of Illinois

My Comm. Expires

Notary Public

in and for the State of Illinois

My Comm. Expires

Notary Public

in and for the State of Illinois

My Comm. Expires

Notary Public

in and for the State of Illinois



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3964  
Registered No.

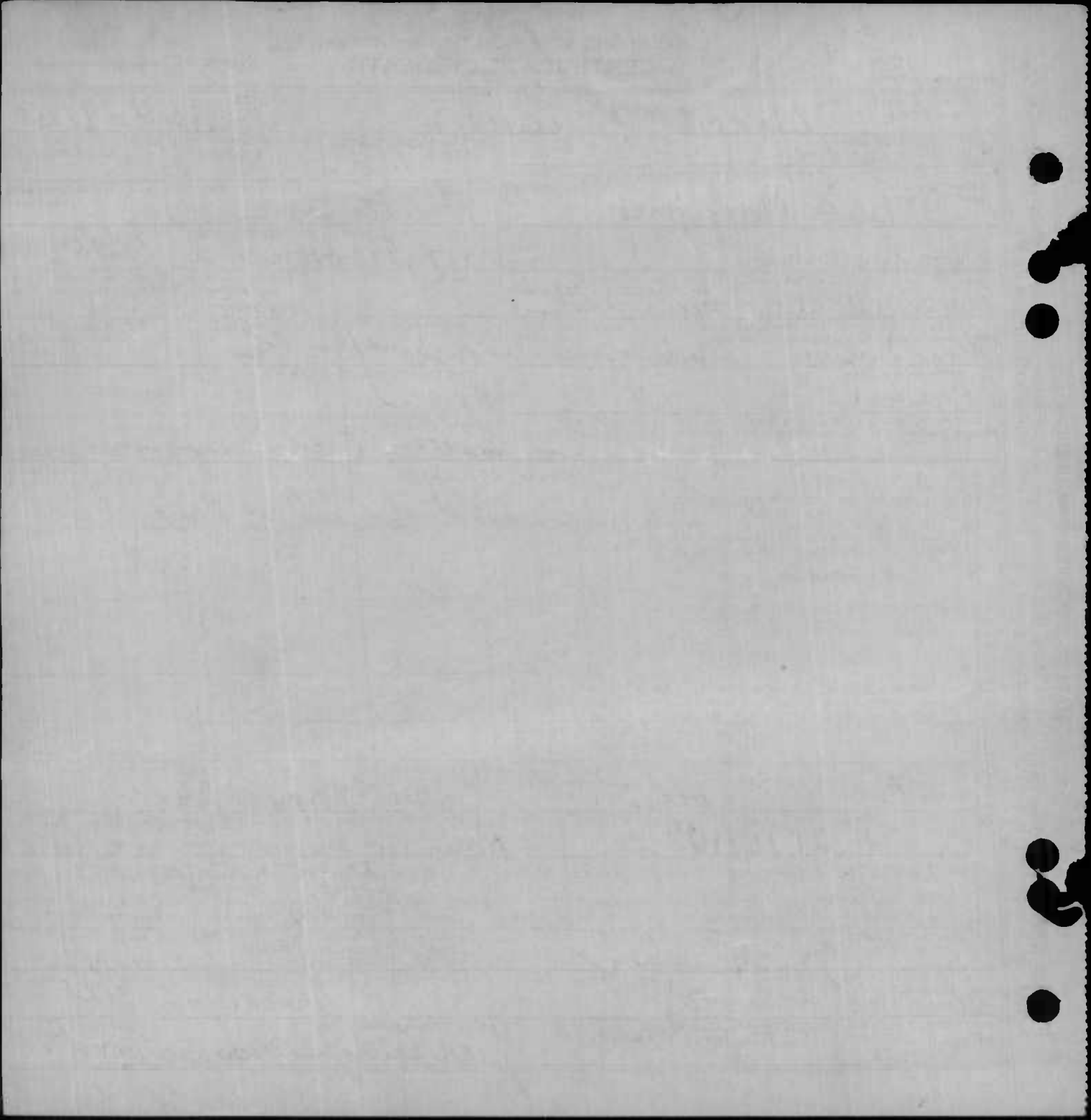
M-426  
BIRTH NO. 50 3964

1. NAME OF DECEASED (Type or Print) <b>MORRIS MULGRUM</b>		2. DATE OF DEATH <b>April 29, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>D.O.A. Mercy Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 13-01</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2417 Brookfield Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>4-4</b>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>	9B. KIND OF BUSINESS OR INDUSTRY <b>selling machine</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>David</b>		14. MOTHER'S MAIDEN NAME <b>Rose</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Martha Mulgrum</b>		ADDRESS <b>2417 Brookfield</b>	

18. <b>E-976</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of heart</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <b>Gunshot wound of heart</b> (A) DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21a. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>office</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>844 PARK AVE</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>4 29 1950 11:45</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Shot another man then shot himself with 30-30 rifle</b>
22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <b>R S Fisher</b>	23B. CHIEF MEDICAL EXAMINER..... M. D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <b>4/30/50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>4-30-50</b>	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State) <b>Brooklyn NY</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Jack Lewis &amp; Sons</b>	ADDRESS <b>2100 Eataut Rd</b>



B-220  
50 3965BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3965  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Louis Bogash

2. DATE  
OF  
DEATH

April 29 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

D.O.A. Md. Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

6001 Wallis Ave

c. Length of stay in Baltimore

43

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, or if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Margaret Bogash, 6001 Wallis Ave

18. E 981

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Gunshot wound of chest  
with heart and lung  
injury.

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT WORK ☒ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

R S Fisher

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR

23C. DATE SIGNED

4/30/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

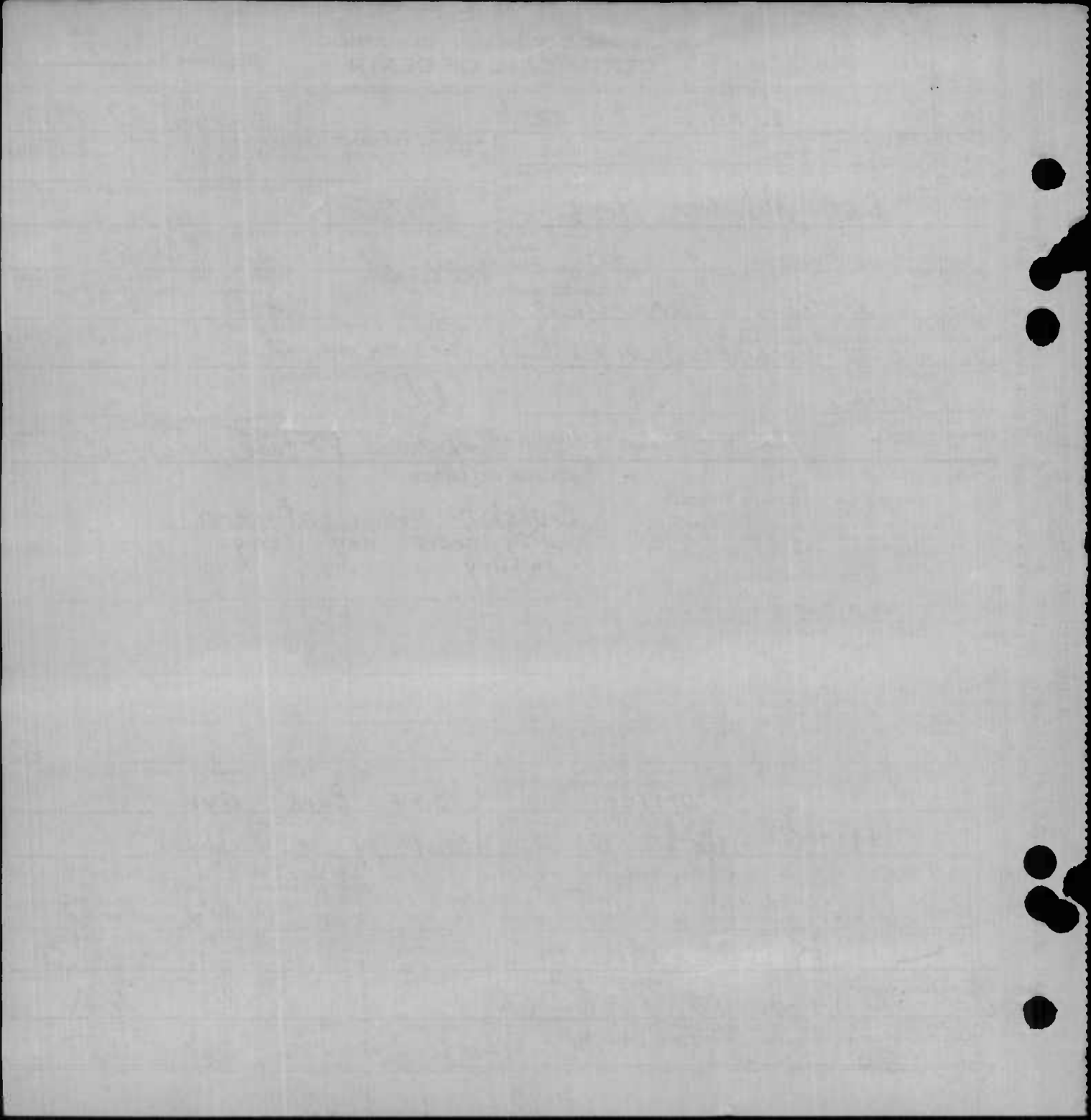
APR 30 1950

N-8614

156 df

166 V

MARGIN RESERVED FOR BINDING  
PLEASE WRITE ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The  
correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE CORRECTED 5-9-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SIDNEY Chayt

2. DATE  
OF  
DEATH

4-29-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

3900 STRATHMORE AVE

BALTO.

27-20

c. Length of stay in Baltimore

LIFE

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

3900 STRATHMORE AVE

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1905  
May 10, (+804)9. AGE (in years-  
last birthday)

41 (45)

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

ATTORNEY

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

SAMUEL

14. MOTHER'S MAIDEN NAME

Ida

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

EDNA Chayt - 3900 STRATHMORE AVE

18.

260X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

Immediate

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertension

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diabetes

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK ☐AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1932 to 4/29/1950, that I last saw the deceased alive on 4/18, 1950, and that death occurred at 7:30 A.m., from the causes and on the date stated above.

23A. SIGNATURE

A. Weiss

M. D.

23B. ADDRESS

1927 E. North Ave.

23C. DATE SIGNED

4/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

4-30-1950

24C. NAME OF CEMETERY OR CREMATORY

SHARPE TFILOH

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis, Inc - 2100 Eutaw Pl

APR 30 1950

V 2693

61





PLEASE WRITE IN FULLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 3967**

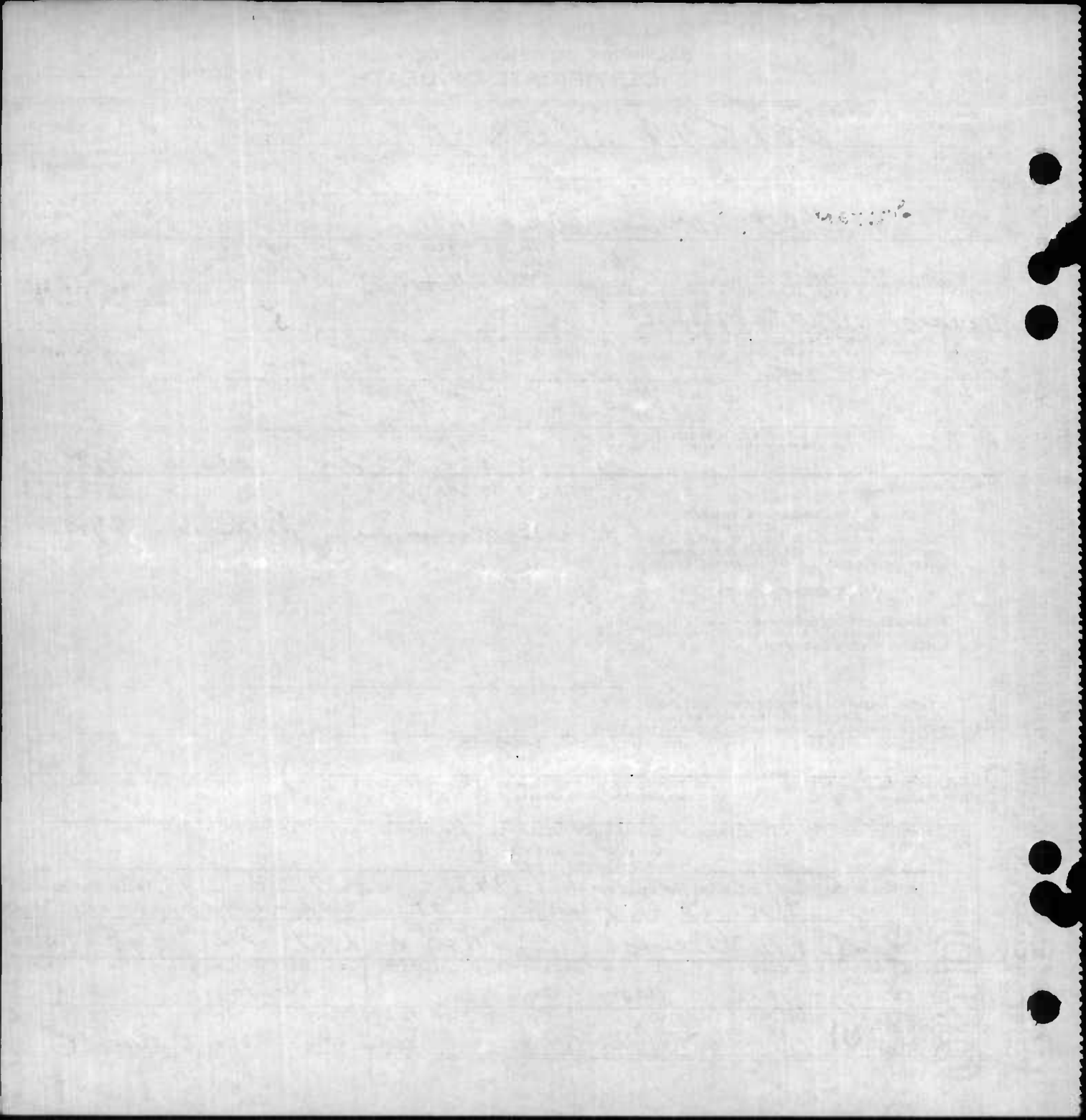
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BERTHA WEXLER</b>		2. DATE OF DEATH <b>4-28-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>1830 West North Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>15-04</b>	
C. Length of stay in Baltimore <b>40</b> Yrs. <del>Mo</del> <del>Days</del>		D. STREET ADDRESS (If rural, give location) <b>1830 West North Ave</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>5-8</b>
9. AGE (In years, last birthday) <b>58</b>		10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Morris Steinhorn</b>		14. MOTHER'S MAIDEN NAME <b>Tobie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Abe Wexler</b>		ADDRESS <b>1830 W North Ave</b>	

18. <b>154X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Adenocarcinoma of Rectum</b> (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>49W</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>1947</b> , 19, to <b>4/28</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/28</b> , 19 <b>50</b> , and that death occurred at <b>3A</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <b>Edward A. Hallins</b> M. D.	23B. ADDRESS <b>1847 W. North Ave</b>	23C. DATE SIGNED <b>4-28-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4-30-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>
24D. LOCATION (City, town, or county) <b>BALTO.</b>		(State) <b>MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 30 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Jack Lewis Inc - 2100 Eutan Pl</b>

VS 150

467



50 3968

50 3968

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

T-260

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

MAX TOCKER

2. DATE  
OF  
DEATH

4-28-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
a. STATE b. COUNTY before admission)

Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

200 No Paterson Park Ave

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 6-03

c. Length of stay in Baltimore

56

Yrs.  
Mos.  
Days

d. STREET ADDRESS (If rural, give location)

200 No Paterson Park Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (in years,  
last birth day)

67

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Shoe maker

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Isaac

14. MOTHER'S MAIDEN NAME

Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Tucker 200 No Paterson Park Ave

18.

151X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Carcinoma of the Stomach

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 20, 1949, to April 28, 1950, that I last saw the  
deceased alive on April 28, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Lancel C. M.D.

23B. ADDRESS

1201 E. Mt. Airy

23C. DATE SIGNED

4/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

4-30-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Herring Hill

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Jack Lewis 2100 Eutaw Rd

VS 150

35489

46B

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S. Legum  
Purdie

K-250  
50 3969

KIKEN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

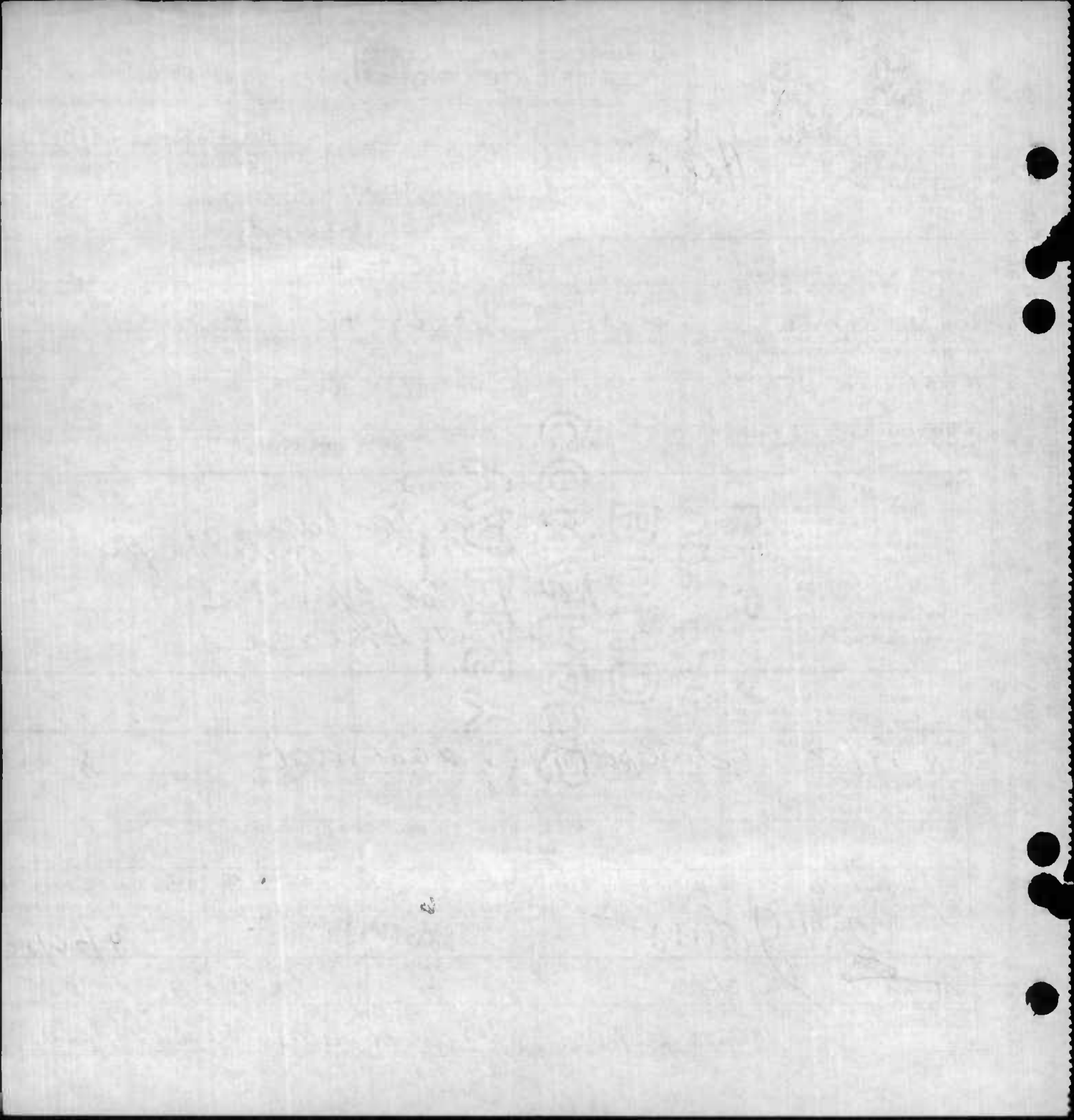
X  
50 3969  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Roland Kiken</i>		2. DATE OF DEATH <i>April 29, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Feb 3</i>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>N.C.</i> B. COUNTY <i>V-30</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Peachland</i>			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>Route # 1</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3-24-46</i>	9. AGE (in years last birthday) <i>4</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS	
18. <i>754.6</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <i>Cardiac Failure</i> (A) <i>following operation for</i> DUE TO <i>Congenital Cyanotic</i> (B) <i>Heart Disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>4/29/50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Disposition of Great Vessels</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-18</i> , 1950, to <i>4-29</i> , 1950, that I last saw the deceased alive on <i>4-29</i> , 1950, and that death occurred at <i>6:10 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>J. P. Johns</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>4/29/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>May 3/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wadesboro N.C.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Harry H. Chumaco</i> ADDRESS <i>4204 Redwood Ave.</i>	

APR 30 1950

157E







R-163  
50 3970BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3970

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Andrew V Roberts

2. DATE  
OF  
DEATH

April 28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1931 Lammont

4. USUAL RESIDENCE (Where deceased lived, institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
(If not in hospital or institution, give street address or  
location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give  
township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

450.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

137

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Jan 49 19, to 28 Apr 50, that I last saw the  
deceased alive on 28 Apr, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

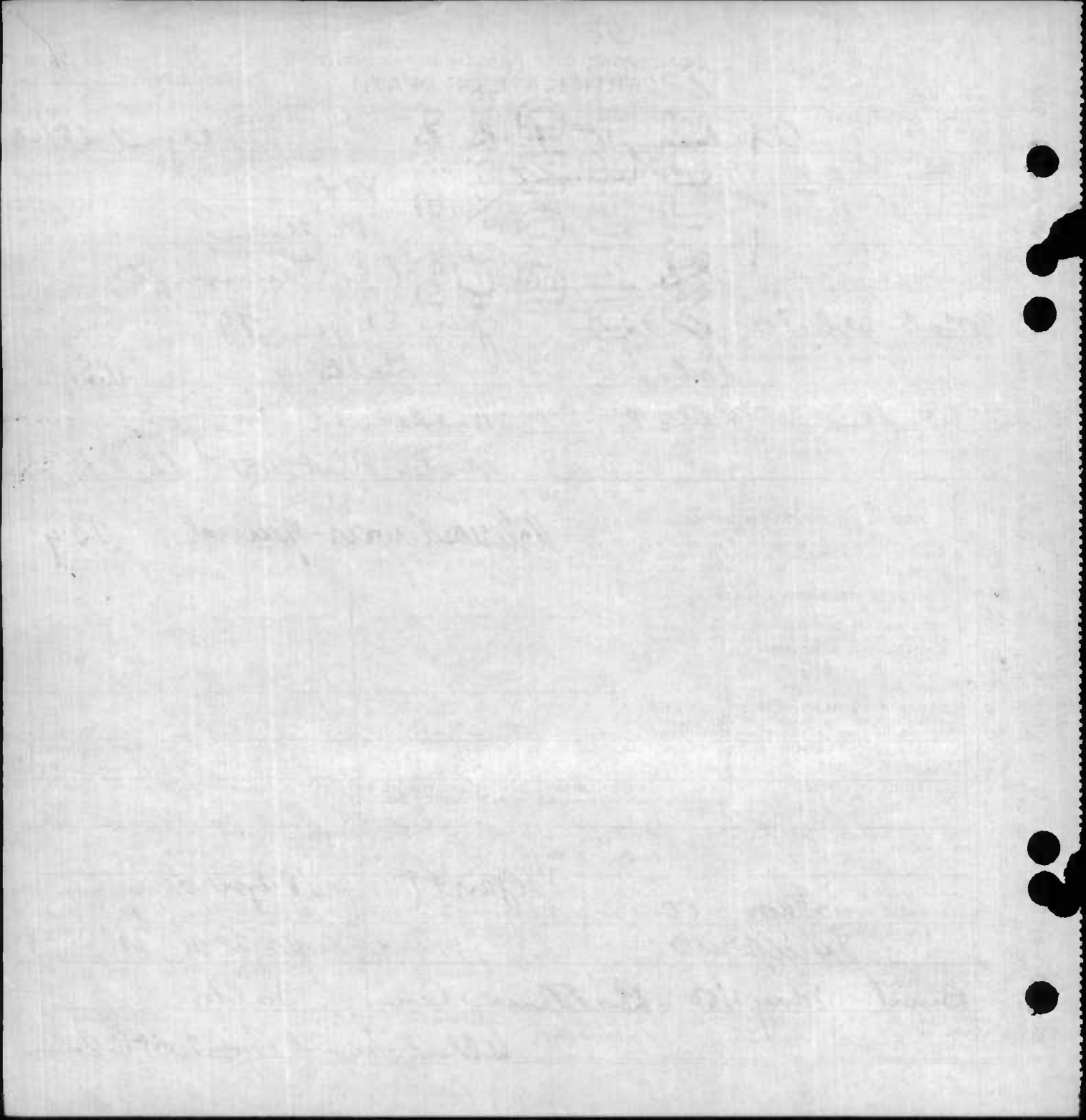
ADDRESS

VS 150

97

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



6-635  
50 3971

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3971

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Kenneth Erdman

2. DATE  
OF  
DEATH

4-29-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

St. Joseph Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 27-34

O. STREET ADDRESS (If rural, give location)

3819 White Avenue - 6

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

5-28-85

9. AGE (In years last birthday)

64

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 331X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

Q. U. E. T. O

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Q. U. E. T. O

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-28, 1950 to 4-29, 1950 that I last saw the deceased alive on 4-29, 1950, and that death occurred at 12:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE

S. K. Haan M. O.

23B. ADDRESS

St. Joseph Hospital

23C. DATE SIGNED

4-29-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 2 1950

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Balto Co

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Winnington Williams, M.D.

25. FUNERAL DIRECTOR

Ullrich Funeral Home 2004 Calver

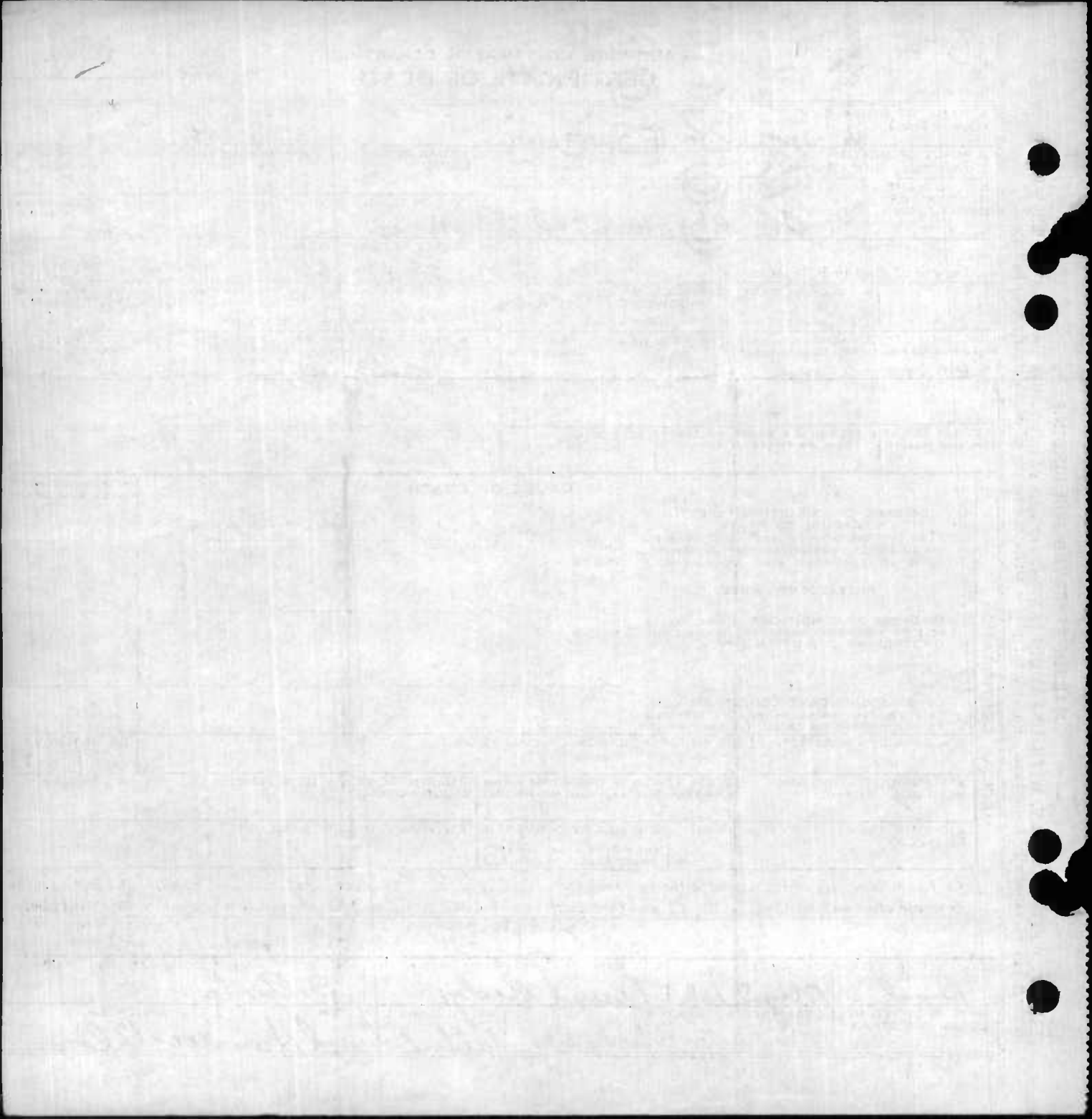
ADDRESS

APR 30 1950

21093

83a

MARGIN RESERVED FOR BINDING  
PLEASE WRITE FULLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3972

Registered No. \_\_\_\_\_

BIRTH NO. 50 3972

1. NAME OF DECEASED (Type or Print) <b>Agnes Cecelia Fitzpatrick</b>			2. DATE OF DEATH <b>Apr. 27, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1121 Valley St</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>90</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 10-01</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>1121 Valley St</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 3, 1870</b>	9. AGE (In years: last birthday) <b>79</b>	If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Hugh Fitzpatrick</b>			14. MOTHER'S MAIDEN NAME <b>Bridget Reilly</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>Mrs. John Batterden 1121 Valley St</b>		

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>acute Cerebral Hemorrhage</b> DUE TO <b>General Arterial Sclerosis</b> DUE TO <b>-</b> DUE TO <b>-</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/17</b> , 19 <b>50</b> , to <b>4/27</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/27</b> , 19 <b>50</b> , and that death occurred at <b>10 A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>A. H. Hornstein</b>		23B. ADDRESS M. D. <b>204 E. Biddle St</b>		23C. DATE SIGNED <b>4/29/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 1 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		25. FUNERAL DIRECTOR ADDRESS <b>Rita Wiedefeld 900 E Biddle St</b>			

MEDICAL CERTIFICATION

VS 150

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100% BAG

END

CONGRESS

WATKINS



MARGIN RESERVED FOR BINDING

USE WRITING ONLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**GAILIUNAS**  
BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

50 3973  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

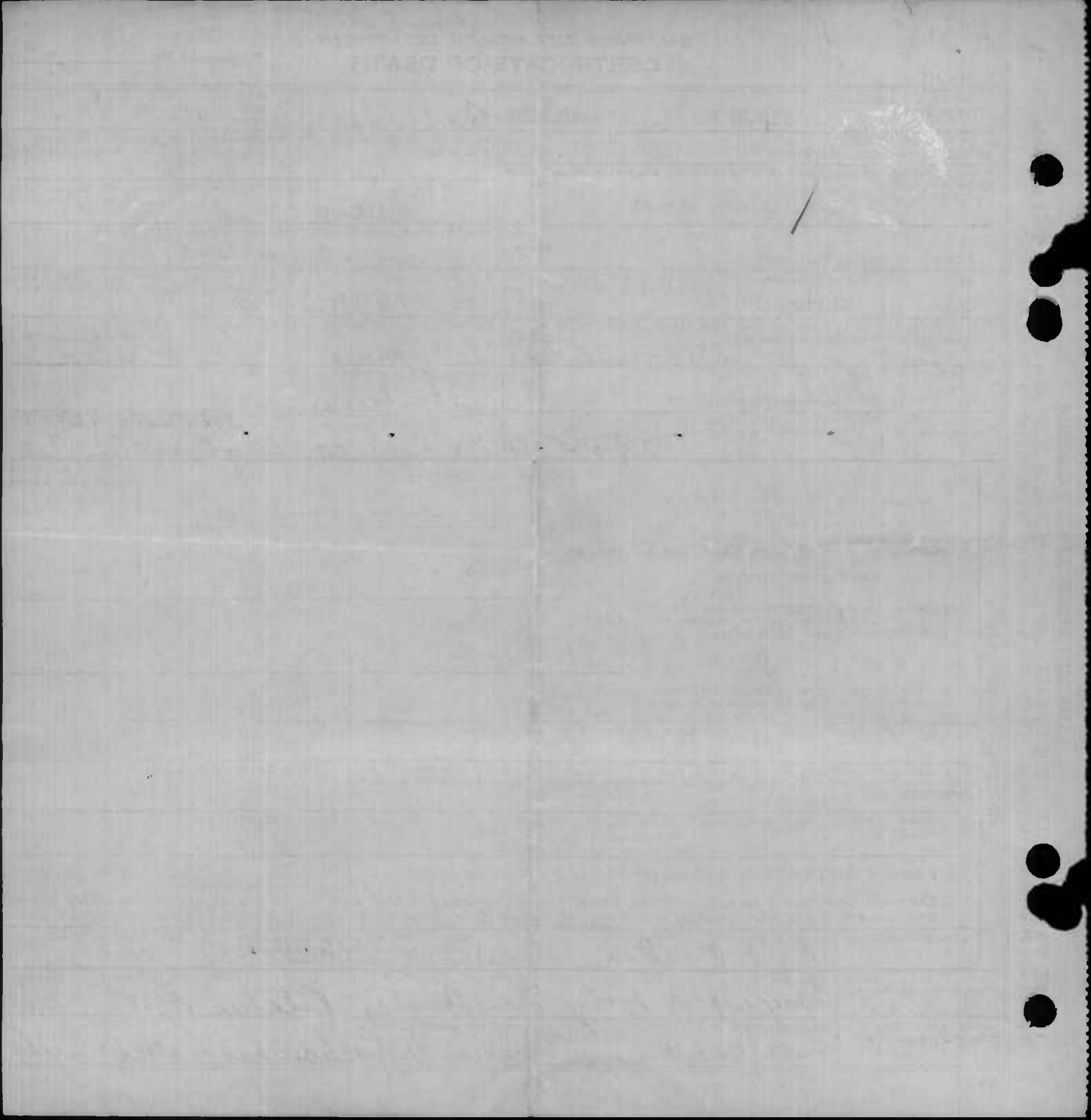
1. NAME OF DECEASED (Type or Print) <b>VINCENT</b>			2. DATE OF DEATH <b>April 27, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>422 W. Camden Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 22-02</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>422 W. Camden Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH <b>= 1895</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STULMAS TRILORS</b>	11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>217-07-7571</b>	17. INFORMANT <b>MR LOVIZA - LITH RMR ATL. CLUB</b>		

18. <b>490 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>LOBAR PNEUMONIA, right upper lobe</b> DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>4/27/50</b>		19B. MAJOR FINDINGS OF OPERATION _____	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <b>R. S. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>4/27/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>May 1, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Pitchee Hg. Ind</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>APR 30 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>Charles W. Pachauskas To McHenry St</b>	

VS 151

360 06

108



M-525

50 3974

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Mankamyer

50 3974

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marilyn Mankamyer

2. DATE  
OF  
DEATH

April 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Sand Patch

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

8-8-04

9. AGE (In years  
last birthday)

45

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CARDENOR

10B. KIND OF BUSINESS OR  
INDUSTRY

COAL MINE

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Lewis Mankamyer

14. MOTHER'S MAIDEN NAME

Eleanor Bettner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

CAUSE OF DEATH

Brain Tumor - 4th ventricle One year

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

Astrocytoma (benign)

over

(C) .....

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19 Apr 50

19B. MAJOR FINDINGS OF OPERATION

Tumor 4th ventricle

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., to or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-13, 1950 to 4-29, 1950, that I last saw the  
deceased alive on 4-29, 1950, and that death occurred at 5:40 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Robert F. Fickel

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

30 Apr 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

4/30/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Bryndale Pa.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Walter H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Fickner &amp; Sons 24 Pa Ave

VS 150

APR 30 1950

308V2

75

561

Letter in document file 50-3974-6/26/50.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3975

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SUSAN B ADAMS

2. DATE  
OF  
DEATH

4-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALT.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

9-03

c. Length of stay in Baltimore

75

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

511 CHESTNUT HILL

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

12-14-1874

9. AGE (In years  
last birthday)

75

If Under 1 Year

Months: Days

5

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

WILLIAM WIEGEL

14. MOTHER'S MAIDEN NAME

ELIZABETH ZACHARY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

No

17. INFORMANT (BROTHER)

GEORGE WIEGEL

ADDRESS

511 CHESTNUT OVERBALT.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Cardiovascular Disease

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Decubitous Ulcers

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 27, 1950, to April 28, 1950, that I last saw the deceased alive on April 28, 1950, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. Frank Supple, III

M. D.

23B. ADDRESS

Union Memorial Hosp

23C. DATE SIGNED

4/28/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAY 1 1950

Winnington Williams, M.D.

Tulhorn, Robt. Inc.

12457 Can





G-150 50 3976

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3976

Registered No. \_\_\_\_\_

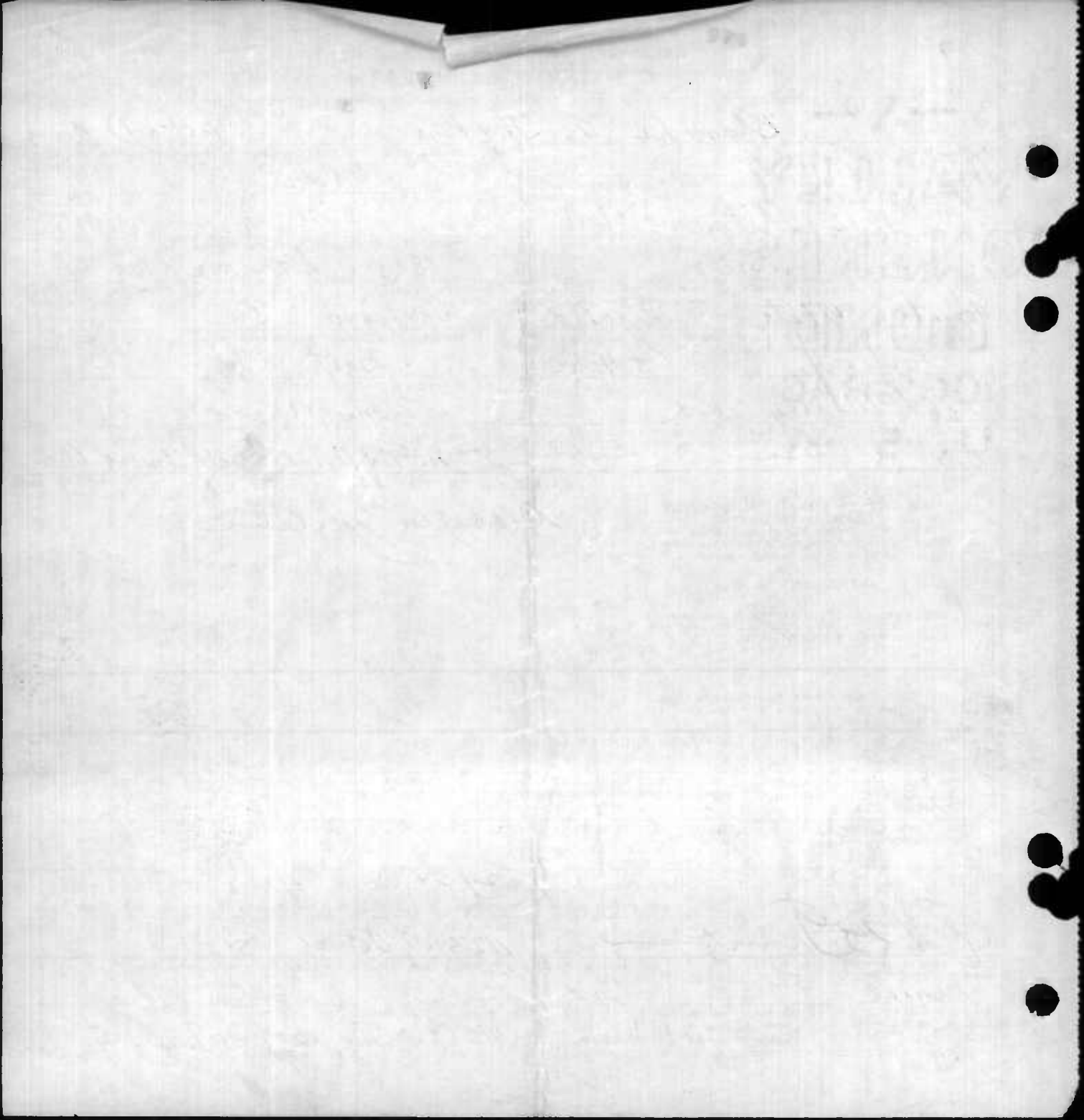
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Blanche V. Giffin</i>		2. DATE OF DEATH <i>4/28/50 12 Noon</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		B. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) C. STATE <i>md.</i> D. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1813 Whitmore Ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 15-03</i>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>1813 Whitmore Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>9/14/1890</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	9. AGE (In years last birthday) <i>59</i>
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>John Wesley Cook</i>		14. MOTHER'S MAIDEN NAME <i>Mary AKers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Wm H. Giffin</i>		ADDRESS <i>1813 Whitmore Ave</i>	

18. <i>260X 1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Diabetes Mellitus</i>		CAUSE OF DEATH <i>Diabetes Mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH _____	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) _____ BUE TO _____ (B) _____ CUE TO _____ (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION _____			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>2/24, 1950</i> , to <i>4/28, 1950</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <i>1123 So Penn St</i>		23C. DATE SIGNED _____	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/1/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>MAY - 1 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, Md</i>		25. FUNERAL DIRECTOR <i>Wm Cook Inc. 1217 St. Paul St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



S-600

50 3977

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3977

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Munson Sawyer

2. DATE  
OF  
DEATH

April 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

The Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Pennsylvania

B. COUNTY

V-35

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Emporium

D. STREET ADDRESS (If rural, give location)

370 E. Allegany Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Feb 6 1972

9. AGE (In years  
last birthday)

28

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR  
INDUSTRY

Auto. Repairs

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James S. Sawyer

14. MOTHER'S MAIDEN NAME

Margaret Munson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Hospital Records

ADDRESS

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

8 hrs

DUE TO

Essential

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

malignant Hypertension

years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

April 28, 1950

19B. MAJOR FINDINGS OF OPERATION

Sympathectomy not completed because of Post-Operative

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 24, 1950, to April 30, 1950, that I last saw the deceased alive on April 30, 1950, and that death occurred at 11:45 Am., from the causes and on the date stated above.

23A. SIGNATURE

Francis Harnett Wain

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

4-30-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

Apr 30, 50

24C. NAME OF CEMETERY OR CREMATORY

Newton Cemetery

24D. LOCATION (City, town, or county)

Emporium, Penna.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

MAY 1 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm Cook Inc

ADDRESS

1217 St Paul St. Balto 2, Md

VS 150

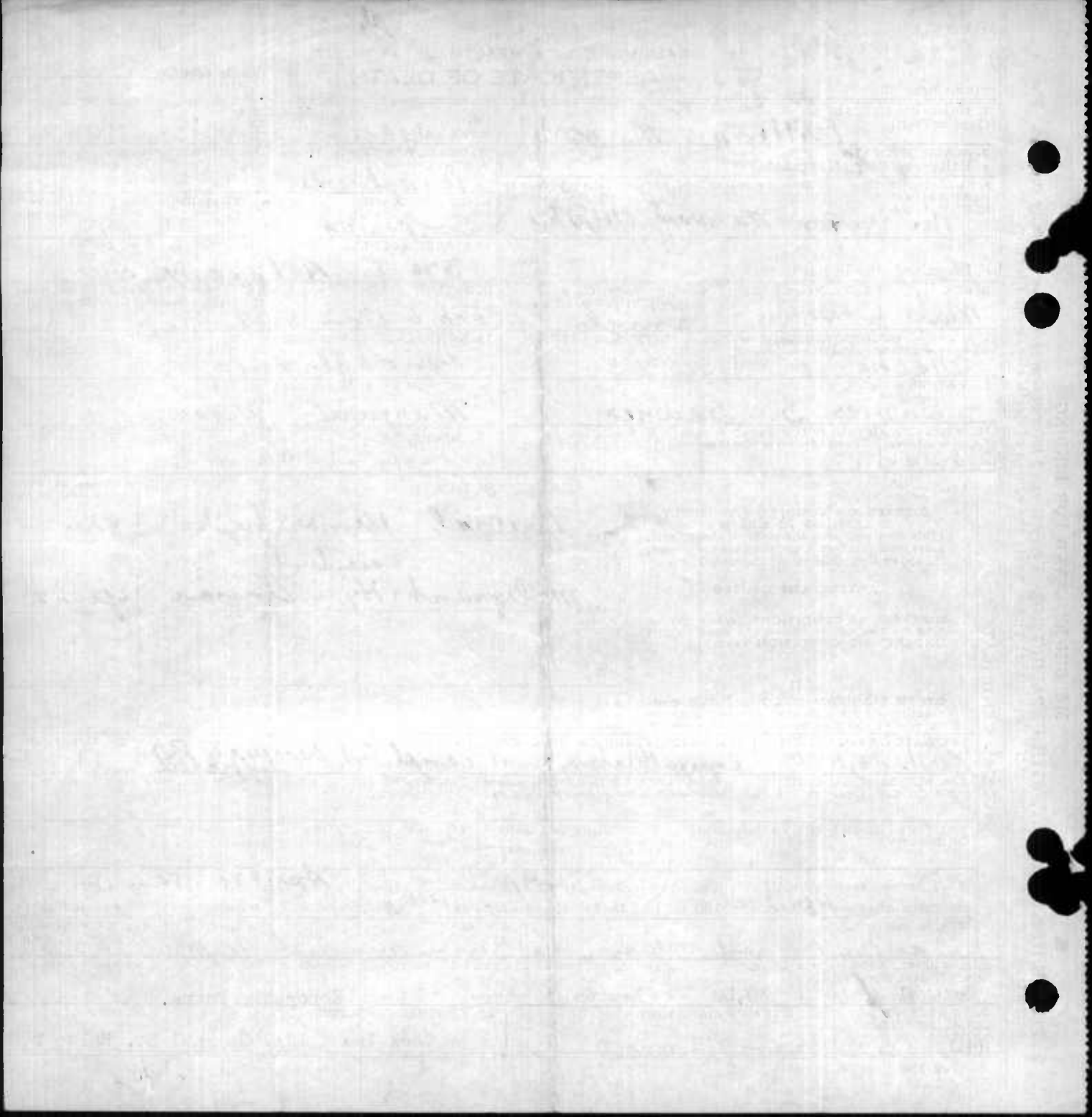
33284

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be fully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Edward Elmer JONES

2. DATE  
OF DEATH Apr 30, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.B. COUNTY  
Prince George SOMERSET

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

U. S. Marine Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Princess Anne

D. STREET ADDRESS (If rural, give location)

Route 2

c. Length of stay in Baltimore

unkn

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar 2, 1889

9. AGE (In years last birthday)

61

10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Seafarer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Jones

14. MOTHER'S MAIDEN NAME

Molly Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

unkn

16. SOCIAL SECURITY NO.

17. INFORMANT

Records

ADDRESS

US Marine Hospital

18. 177x

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ..... Adenocarcinoma of prostate with

metastasis to vertebrae and to pelvic bones.

ANTECEDENT CAUSES

(B) .....

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) .....

none

unkn.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Jan 26, 1948

19B. MAJOR FINDINGS OF OPERATION

as above

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 12, 1950, to April 30, 1950 that I last saw the deceased alive on April 30, 1950, and that death occurred at 4:25 pm., from the causes and on the date stated above.

23A. SIGNATURE

William Bernick

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/2/50

24C. NAME OF CEMETERY OR CREMATORY

St Paul Cemetery

24D. LOCATION (City, town, or county)

Princess Anne Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAY 1 - 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Daphne's Funeral Home - Princess Anne

ADDRESS

512 Conwellton Md.

STATE OF TEXAS

County of \_\_\_\_\_

State of \_\_\_\_\_

Know all men by these presents, \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Bessie M. Leech</i>			2. DATE OF DEATH <i>4-30-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Ind</i> B. COUNTY <i>Harford</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Fallston 6200</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Sept 18 1890</i>	9. AGE (In years last birthday) <i>60 59</i>	10. BIRTHPLACE (State or foreign country) <i>Maryland Md</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			12. CITIZEN OF WHAT COUNTRY? <i>—</i>		
13. FATHER'S NAME <i>Wm Leech</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Cochran Cochran</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			17. INFORMANT <i>J. Golden Murphy Fallston Md</i>		
16. SOCIAL SECURITY NO.			ADDRESS		

18. *443X*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

*Cerebral Embolus*

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

*4 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

*Auricular Fibrillation*

DUE TO

*Sev. weeks*

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

*Diabetes Mellitus*

*Sev. years*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-25*, 19*50*, to *4-30*, 19*50*, that I last saw the deceased alive on *4-30*, 19*50*, and that death occurred at *10:55 AM*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Apr 10 1892  
Tennessee  
F. J. [illegible]  
[illegible]

Apr 10 1892  
Tennessee  
F. J. [illegible]  
[illegible]

Apr 10 1892  
Tennessee  
F. J. [illegible]  
[illegible]

Apr 10 1892  
Tennessee  
F. J. [illegible]  
[illegible]

R-360 50 3980

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3980  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George E. Ritter

2. DATE  
OF  
DEATH

April 29/50

3. PLACE OF DEATH

A. Baltimore City, Maryland

3621 W. Belvedere

4. USUAL RESIDENCE (Where deceased lived. If institution / residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

3621 W. Belvedere Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 8, 1879

9. AGE (In years,

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Watchman Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Canton Railroad

11. BIRTHPLACE (State or foreign country)

Woodlawn, Md

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William R. Ritter

14. MOTHER'S MAIDEN NAME

Martha M. Cullough

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Geo. E. Ritter 3621 W. Belvedere Ave

18. 162 X 1 002 X

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Pulmonary Tuberculosis 1 yr.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Pulmonary Carcinoma 1 yr.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office hldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT

NOT WHILE

m.

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1948 to April 29, 1950, that I last saw the  
deceased alive on April 29, 1950, and that death occurred at 9:00 m., from the causes and on the date stated above.

23A. SIGNATURE

L. G. Zach

M. D.

23B. ADDRESS

3517 Edmonson

23C. DATE SIGNED

Apr 30, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

May 2/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

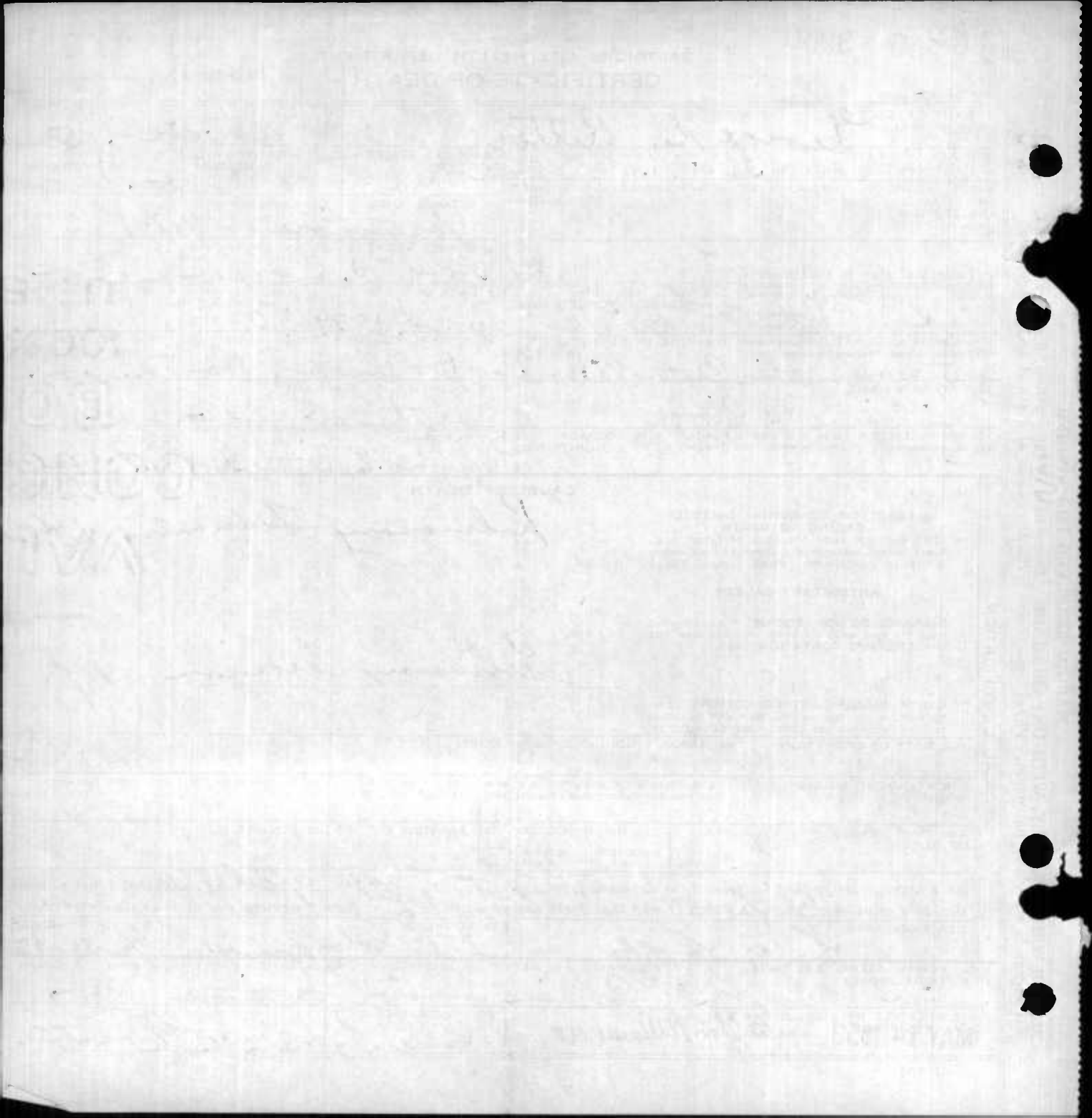
REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Loring Myers 5005 Philadelphia Ave



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

DAVID RUBIN

2. DATE  
OF  
DEATH

4/30/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

\_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Sumner Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-13

D. STREET ADDRESS (If rural, give location)

2424 Loyola Southway

C. Length of stay in Baltimore

47 Yrs

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

April 15, 1880

9. AGE (In years last birthday)

70

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Grocer Business

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Menasha Rubin

14. MOTHER'S MAIDEN NAME

Mollie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
Samuel S Rubin 2424 Loyola Southway

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

? 24 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis

DUE TO

? 24 hrs

(C) Hypertensive Cardiovascular Disease

Years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

① Diabetes Mellitus ② Syphilis Arthritis - left knee

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 4/29, 1950, to 4/30, 1950, that I last saw the deceased alive on 4/30, 1950, and that death occurred at 6:30 AM., from the causes and on the date stated above.

23A. SIGNATURE

Leon E. Kanel

M. D.

23B. ADDRESS

Sumner Hospital

23C. DATE SIGNED

4/30/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Rosedale Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Sol Levenson & Bros

ADDRESS

1126 W North Ave



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
OFFICE OF THE COMMISSIONER  
ALBANY, N. Y.

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925



C-510

50 3982

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3982

Registered No. \_\_\_\_\_

BIRTH NO. 50-08497

1. NAME OF DECEASED  
(Type or Print)

John Lawrence Canby

2. DATE

OF DEATH Apr. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Sinai Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2430 W. Maryland Ave. # 18

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
S

8. DATE OF BIRTH

Apr. 25, 1950

9. AGE (In years last birthday)

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

9 1/2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jerome Pearce Canby

14. MOTHER'S MAIDEN NAME

Mary Catherine Whittemore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Mary Canby - 2430 W. Maryland Ave. # 18

18. 770.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Erythroblastosis fetalis

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 25, 1950, to April 26, 1950, that I last saw the deceased alive on April 26, 1950, and that death occurred at 4:25 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert J. Weiss

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

JOHN HOPKINS MEDICAL SCHOOL APR 28 1950

DATE RECEIVED BY SOCIAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAY 1 - 1950

Huntington Williams, M.D.

Commissioner of Health

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
DATE OF BIRTH		PLACE OF BIRTH		MARRIED		OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF REGISTRAR	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3983

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Hannah Gait her

2. DATE  
OF  
DEATH

4/29/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Howard

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

40 St. Agnes

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

6200

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

2-13-97

9. AGE (In years last birthday)

53

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. K. Gaither

14. MOTHER'S MAIDEN NAME

Mary Reyes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Mrs. L. H. Fort, Ellicott City, Md.

18. 170X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma breast

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

c metastasis

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1-15-50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma breast

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-12-1950 to 4-28-1950, that I last saw the deceased alive on 4-28-1950, and that death occurred at 6 AM., from the causes and on the date stated above.

23A. SIGNATURE

Frank O'Day, M.D.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

4-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

May 1-1950

24C. NAME OF CEMETERY OR CREMATORY

St. Agnes City Howard Co Md

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Baltimore Ave 2224 Charles St.

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]*

*[Two distinct, dark ink marks or signatures, possibly 'D' and 'M', written over the faint background text.]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 3984**

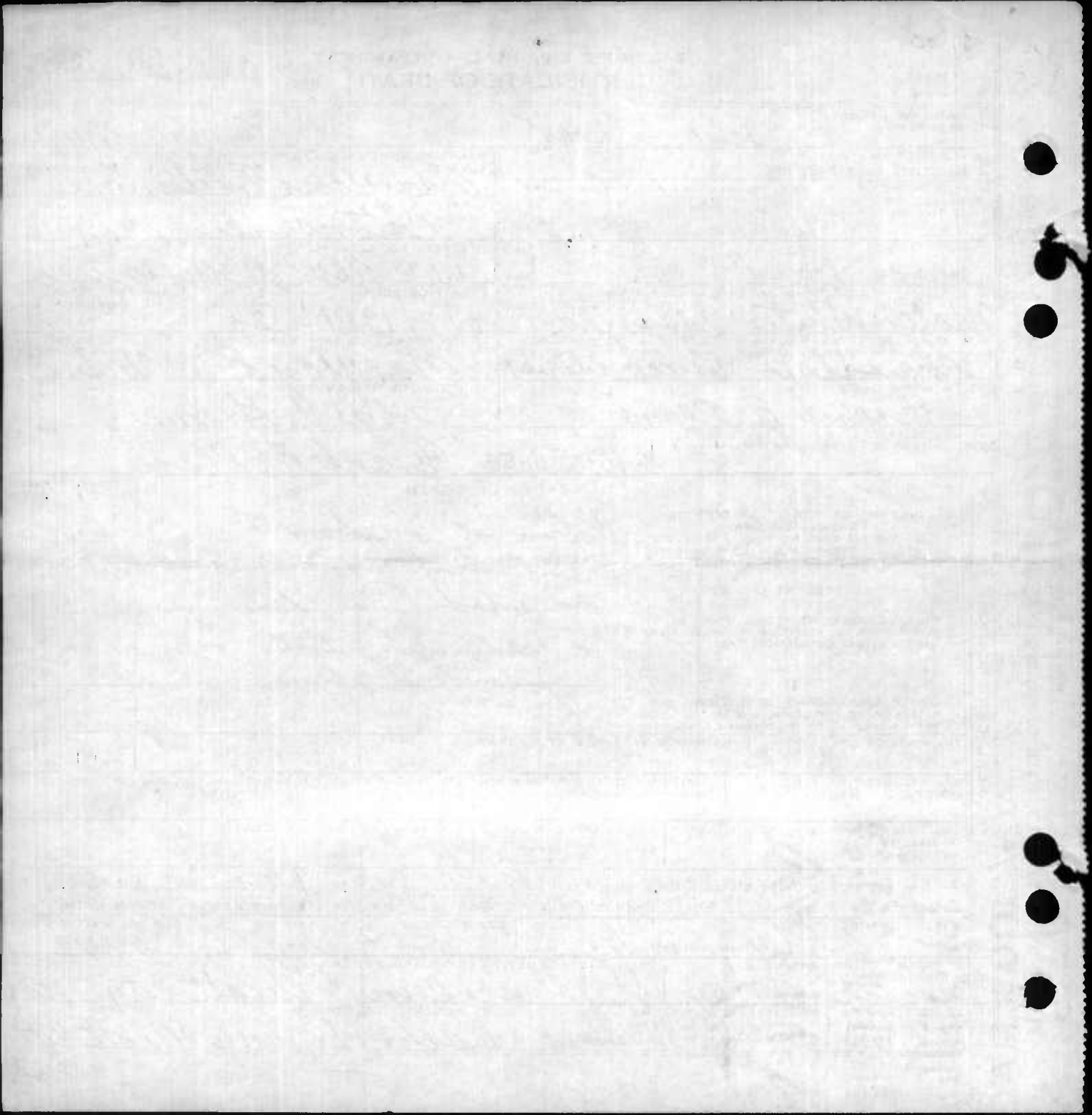
BIRTH NO. **2984**

1. NAME OF DECEASED (Type or Print) <b>ALVIN CLARK</b>		2. DATE OF DEATH <b>April 27, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Catonsville-28, 8200</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>606 Alvin Avenue</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4/8/1917</b>
9. AGE (In years last birthday) <b>33</b>		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Truck driver</b>	
13. FATHER'S NAME <b>Frank E. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Ida R. Grine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>215-10-5657</b>	
17. INFORMANT <b>Frank E. Clark</b>		ADDRESS	

<p>18. <b>4343</b></p> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Antecedent Causes</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center"><b>CAUSE OF DEATH</b></p> <p>(A) <b>Cerebral hypoxemia</b> DUE TO <b>secondary massive intracerebral</b></p> <p>(B) <b>cardiac hemorrhage</b> DUE TO <b>cardiac hypertrophy &amp;</b></p> <p>(C) <b>pulmonary edema</b></p>	<p>INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b></p>

19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 27, 1950</b> , to <b>April 27, 1950</b> , that I last saw the deceased alive on <b>April 27, 1950</b> , and that death occurred at <b>8:55 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>B. Q. Chapman M.D.</b>		23B. ADDRESS <b>University Bldg.</b>		23C. DATE SIGNED <b>4/28/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/1/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Johns Ceme. Ellicott City, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Ellicott City, Md.</b>		25. FUNERAL DIRECTOR <b>Easton Sons Ellicott City</b>		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAY 1 - 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>			







**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3985

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MOSE</b>		2. DATE OF DEATH <b>Apr. 29, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE _____ B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Good SAMARITAN Home.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balt.</b> <b>21-01</b>	
c. Length of stay in Baltimore <b>24 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>915 S. Fremont ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 1885</b>
9. AGE (In years last birthday) <b>54</b>		10. Under 1 Year Months: _____ Days: _____	11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEVER WORKED</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Moses Isabel</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Carter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Magnolia Williams</b>		ADDRESS <b>7018 S. Hayes</b>	

<b>MEDICAL CERTIFICATION</b>	18. <b>443 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION</b>	CAUSE OF DEATH <b>CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION</b>	INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
	ANTECEDENT CAUSES	(A) DUE TO	
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO <b>Hypertensive Cardio-vascular Disease</b>	<b>?</b>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) DUE TO	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>April 24, 1950</b> to <b>April 29, 1950</b> , that I last saw the deceased alive on <b>April 28, 1950</b> , and that death occurred at <b>7:15 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Melvin N. Borden</b>		23B. ADDRESS <b>2030 W. Fayette St</b>		23C. DATE SIGNED <b>4/29/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 2-51</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>a a co Md</b>		25. FUNERAL DIRECTOR <b>James A. Hayes</b>		ADDRESS <b>638 N. Belvoir</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAY 1 - 1950</b>		REGISTRAR'S SIGNATURE <b>Wmington Williams</b>			

THE STATE OF TEXAS  
COUNTY OF DALLAS

I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, Texas.

Witness my hand and the seal of the County of Dallas, Texas, this 1st day of January, 1901.

Clerk of the County of Dallas, Texas.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-240  
50 3986

SAUCHELLI  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3986

Registered No. \_\_\_\_\_

BIRTH NO. _____			2. DATE OF DEATH <u>April 28, 1950</u>		
1. NAME OF DECEASED (Type or Print) <u>Lena Sauchelli</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Calvert 3356</u> B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>13-07</u>		
c. Length of stay in Baltimore <u>15 years</u> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>Wyman Park Apartments</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 2, 1878</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>New York (Albany)</u>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <u>Oscar Van Valen</u>			14. MOTHER'S MAIDEN NAME <u>Margaret McElroy</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT ADDRESS <u>Union Memorial Hosp. Records</u>		
18. <u>470.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Coronary artery sclerosis</u> DUE TO _____ <u>+ Hypertensive Cardiovascular disease</u> DUE TO _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____					
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>April 17, 1950</u> , to <u>April 28, 1950</u> , that I last saw the deceased alive on <u>April 28, 1950</u> , and that death occurred at <u>12:40</u> m., from the causes and on the date stated above.					
23A. SIGNATURE <u>William A. Rauen</u>		23B. ADDRESS <u>Union Memorial Hospital</u>		23C. DATE SIGNED <u>April 28, 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 1, 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Woodlawn</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (State) <u>Maryland</u>			
DATE RECEIVED BY LOCAL REGISTRAR _____		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR <u>Stewart &amp; Morrow Co., 108 W. North Ave</u>	
				ADDRESS <u>City #1. 937</u>	

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	

R-360

50 3987

50 3987

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>(Mrs) Estelle Barton Rider</i>		2. DATE OF DEATH <i>April 29-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1916 Park Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore Md</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 13-00</i>	
c. Length of stay in Baltimore <i>Leifz</i>		D. STREET ADDRESS (If rural, give location) <i>1916 Park Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug. 4-1879</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired typist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>	9. AGE (In years last birthday) <i>70</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>James S. Barton</i>		14. MOTHER'S MAIDEN NAME <i>Julia Bauer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-10-3578</i>	
17. INFORMANT <i>(Miss) Laura G. Barton Balto Md</i>		ADDRESS <i>1916 Park Ave</i>	

18. <i>592X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Nephritis</i>	CAUSE OF DEATH (A) <i>Chronic Nephritis</i> DUE TO (B) <i>Uremia</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>about 2 years</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <i>May 2 1948</i> , to <i>April 29, 1950</i> , that I last saw the deceased alive on <i>April 29, 1950</i> , and that death occurred at <i>8:55 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Benjamin Kader</i>		23B. ADDRESS <i>M. D. 2306 Eutaw Pl</i>		23C. DATE SIGNED <i>May 1-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>May 2-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>	24D. LOCATION (City, town, or county) <i>Baltimore Md</i>	25. FUNERAL DIRECTOR <i>Seeward Murrell's Sons</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>5/1/50</i>	REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>	ADDRESS _____			

VS. 150

23680

13TB

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



WATLEY  
CERTIFICATE OF DEATH

1. Name of deceased: *John William Watley*  
2. Date of birth: *1915 Jan 15*  
3. Date of death: *1970 Jan 15*  
4. Place of birth: *London, England*  
5. Place of death: *London, England*  
6. Cause of death: *Heart failure*  
7. Signature of medical officer: *[Signature]*  
8. Signature of registrar: *[Signature]*  
9. Date of registration: *1970 Jan 15*  
10. Name of informant: *John Watley*



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 3988

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sarah Miller

2. DATE  
OF  
DEATH

4.30.1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Doctors Hospital

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Doctors Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1309 E. Baltimore St.

c. Length of stay in Baltimore

40 years

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

8.8.1882

9. AGE (in years  
last birthday)

68

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

David

Mayover

14. MOTHER'S MAIDEN NAME

Esther • Jane Mayover

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Joseph Miller 1309 E. Baltimore St

ADDRESS

18. 332X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Acute Cerebral Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

1 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

acute myocardial failure

2 days

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) General atherosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4.25 to 4.30, 1950, to 4.30, 1950, that I last saw the deceased alive on 4.29, 1950, and that death occurred at 2-00 am., from the causes and on the date stated above.

23A. SIGNATURE

S. C. Feldman

M. D.

23B. ADDRESS

1440 E. Baltimore St

23C. DATE SIGNED

4/30/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Reburial

24B. DATE

5-1-50

24C. NAME OF CEMETERY OR CREMATORY

United Hebrew

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewicki

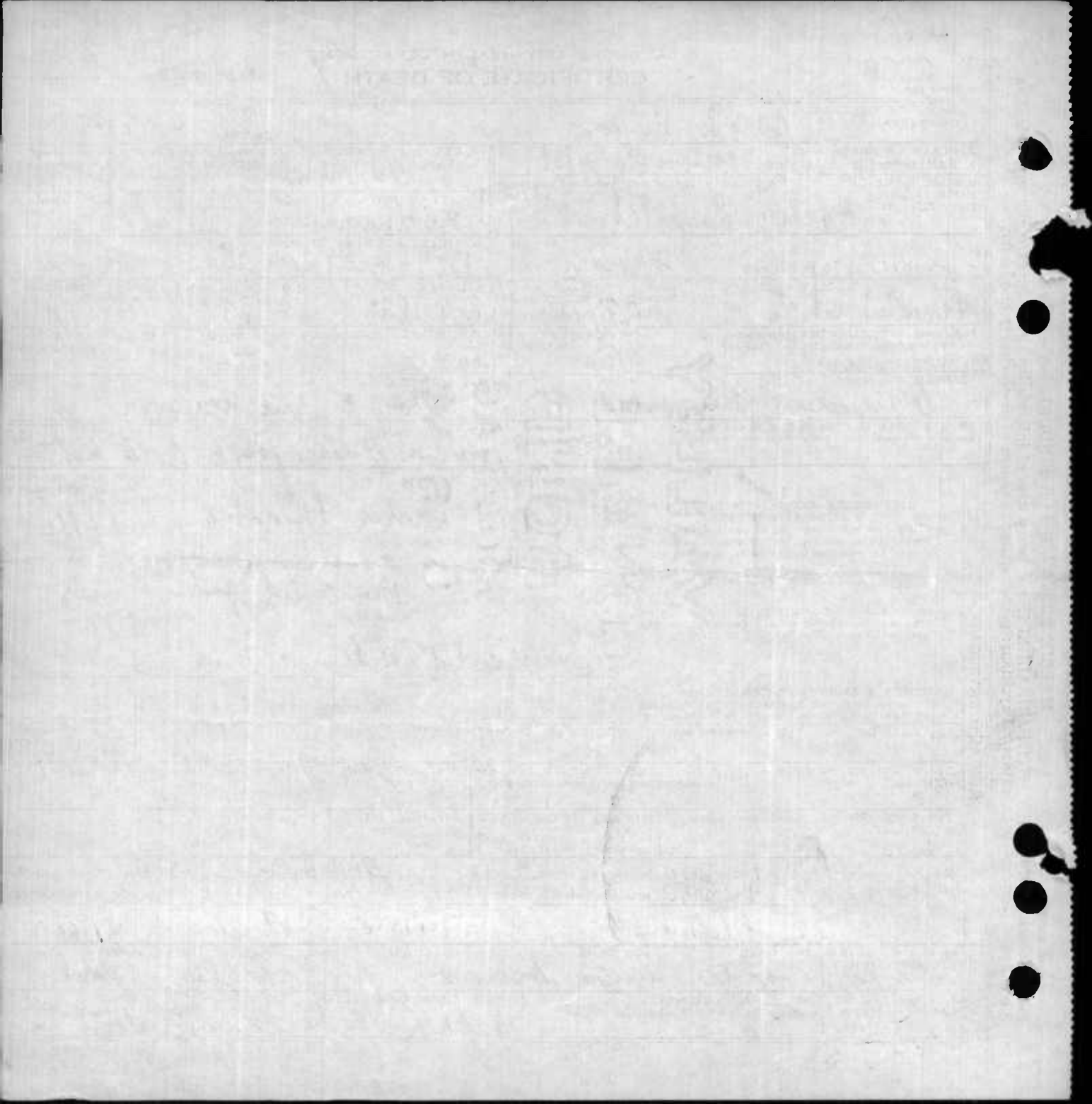
ADDRESS

2100 Easton Rd

MAY 1 - 1950

VS 150

830



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 3989BIRTH NO. 50 39891. NAME OF DECEASED  
(Type or Print)

GRACE J. OTTE

2. DATE  
OF  
DEATH

April 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

Anne Arundel

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

South Baltimore General

C. CITY OR TOWN

Glen Burnie

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

107 Fifth Avenue, S. E.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 9, 1947

9. AGE (In years  
last birthday)

2

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William Otte

14. MOTHER'S MAIDEN NAME

Elinor Sunde

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Mrs. Ray Smith, 109 Fifth Ave., Glen Burnie

ADDRESS

18.

E 812.0  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

## CAUSE OF DEATH

Crushing injury of skull

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

Alley in back of 107 Fifth Ave., S. E.

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

4/28/50 3:00 P. m.

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Child probably crawled under the garbage  
truck, and the truck ran over her22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

4/29/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

MAY 1-1950

24C. NAME OF CEMETERY OR CREMATORY

GLEN HAVEN

24D. LOCATION (City, town, or county)

GLEN BURNIE, MD

DATE RECEIVED BY  
LOCAL REGISTRAR

MAY 7-1950

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Thomas W. Singleton, Glen Burnie, MD

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 3990  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Belzines Christian*

2. DATE  
OF  
DEATH

*April 27, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Balto. City*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

*Ind.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

*5-0*

D. STREET ADDRESS (If rural, give location)

*1115 McElderry St.*

c. Length of stay in Baltimore

*Life*

Yrs.  
Mos.  
Days

5. SEX

*Female*

6. COLOR OR RACE

*colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Widowed*

8. DATE OF BIRTH

*9-30-1900*

9. AGE (in years last birthday)

*49*

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Housewife*

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore Md*

12. CITIZEN OF WHAT COUNTRY?

*U.S.A.*

13. FATHER'S NAME

*Harry*

*Lee*

14. MOTHER'S MAIDEN NAME

*Susie*

*Hill*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

*JOHNS HOPKINS HOSPITAL*

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

*Fibro Cerebral Tuberculosis 8 yrs (active)*

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *4-26*, 1950, to *4-27*, 1950, that I last saw the deceased alive on *4-27*, 1950, and that death occurred at *7 P. m.*, from the causes and on the date stated above.

23a. SIGNATURE

*Susan Calkins*

23b. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24b. DATE

*5/I/1950*

24c. NAME OF CEMETERY OR CREMATORY

*Mt. Calvary Cem.*

24d. LOCATION (City, town, or county)

*Baltimore Md*

(State)

DATE RECEIVED BY REGULAR REGISTRAR

*MAY 1 1950*

25. FUNERAL DIRECTOR

ADDRESS

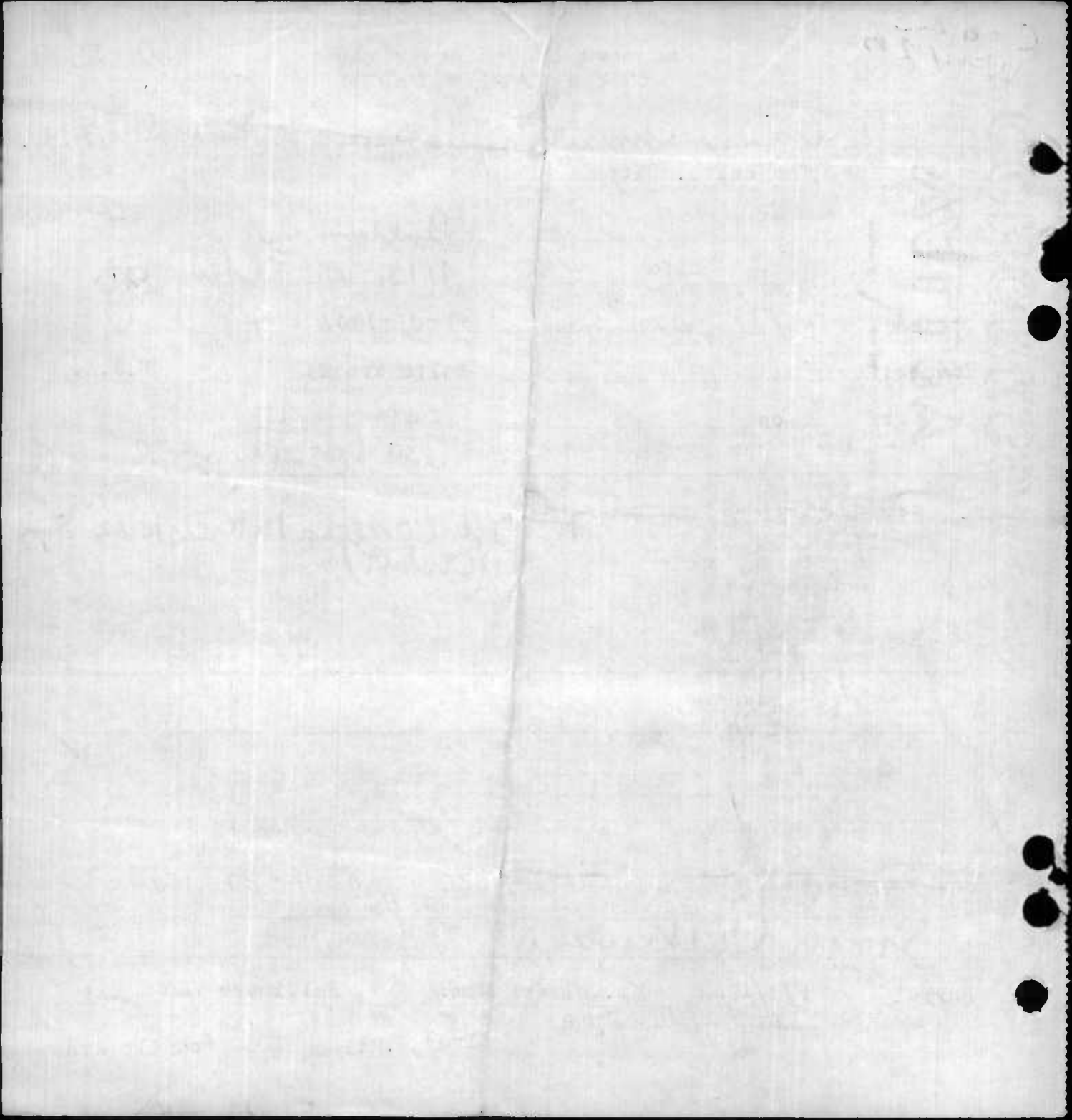
*Elroy O. Wilson 1000 Brantly Ave*

VS 150

*130*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3991

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CATHERINE RIEGEL (SISTER M. EDIGNA)</b>		2. DATE OF DEATH <b>APRIL 30, 1950</b>	
3. PLACE OF DEATH: <b>103 S. MOUNT ST.</b> A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>FOURTEEN HOLY MARTYRS CONVENT</b> <b>103 S. MOUNT ST.</b> <b>14 YEARS</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 19-04</b>	
D. STREET ADDRESS (If rural, give location) <b>103 S. Mount St</b>		9. AGE (In years last birthday) <b>55</b>	
c. Length of stay in Baltimore		10. AGE (In years last birthday) <b>55</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>JAN. 13, 1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13. FATHER'S NAME <b>LOUIS Riegel</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE DONNELLY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>S. Mary Ambrosia</b>		ADDRESS	

18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY THROMBOSIS</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>CORONARY ARTERIO SCLEROSIS</b> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>BRONCHIAL ASTHMA</b>		<b>45 years</b>
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>1-12</b> , 19 <b>35</b> , to <b>4-29</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-29</b> , 19 <b>50</b> , and that death occurred at <b>4 a</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <b>S. Nelson Carey</b> M. D.	23B. ADDRESS <b>1014 So Park St</b>	23C. DATE SIGNED <b>5-1-1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	24B. DATE <b>May 2</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Notch Cliff</b>
24D. LOCATION (City, town, or county) (State) <b>Glen Burn</b>	25. FUNERAL DIRECTOR <b>Geo M. F. Smith</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>MAY 1 - 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, Jr.</b>



PLEASE WRITE IN PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

R-360

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 3992  
Registered No. \_\_\_\_\_

BIRTH NO. 3992

1. NAME OF DECEASED (Type or Print) <b>Albert C Reeder</b>		2. DATE OF DEATH <b>4-28-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Cecil</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>433 E Fort Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>24-04</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>433 E Fort Ave</b>	
5. SEX <b>m</b>	6. COLOR OR RACE <b>N.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>5/27/</b>
9. AGE (In years last birthday) <b>abt 80</b>		H Under 1 Year Months Days	I Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13. FATHER'S NAME <b>John Reeder</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Nicholas Pfister</b>		ADDRESS	
18. <b>42211</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial failure</b> DUE TO <b>Cardio-Vascular disease</b> DUE TO <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4/28</b> , 19 <b>50</b> , to <b>4/28</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4/28</b> , 19 <b>50</b> , and that death occurred at <b>11A.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>D J S Sarano</b>		23B. ADDRESS <b>436 E Fort Ave</b>	
23C. DATE SIGNED <b>4/29/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/2/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	24D. LOCATION (City, town or county) (State) <b>Cooper Lane</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>MAY 1 - 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>J J Foley &amp; Sons</b>		ADDRESS	

STATE OF NEW YORK  
CERTIFICATE OF DEATH

*[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible fragments include:]*

*... of ...*  
*... born ...*  
*... died ...*  
*... at ...*  
*... cause ...*  
*... buried ...*  
*... Registrar ...*  
*... Date ...*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 3993

BIRTH NO. 399350-07717

1. NAME OF DECEASED  
(Type or Print)

*Stanley*

2. DATE OF DEATH

*4-30-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Provident Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Baltimore*

C. Length of stay in Baltimore

*20*

O. STREET ADDRESS (If rural, give location)

*2006 Rayner Ave*

5. SEX

*Male*

6. COLOR OR RACE

*Negro*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*New Born*

8. DATE OF BIRTH

*4-15-50*

9. AGE (In years last birthday)

10. Under 1 Year Months: Days: Hours: Min.

*20*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Baltimore*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Henry Lambert*

14. MOTHER'S MAIDEN NAME

*Beth Ann Lipscomb*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mother 2006 Rayner Ave*

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

*Sepsis*

DOE TO

ANTECEDENT CAUSES

(B)

*Diabetes, Prematurity*

DOE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *4-15*, 1950, to *4-30*, 1950, that I last saw the deceased alive on *4-30*, 1950, and that death occurred at *7:30* m., from the causes and on the date stated above.

23A. SIGNATURE

*Dr. J. P. [Signature]*

M. O.

23B. ADDRESS

*Provident Hosp*

23C. DATE SIGNED

*4-30-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Burial May 2, 1950 Mt. Bethel Cemetery Danville, Virginia*

*Holland Funeral Home*

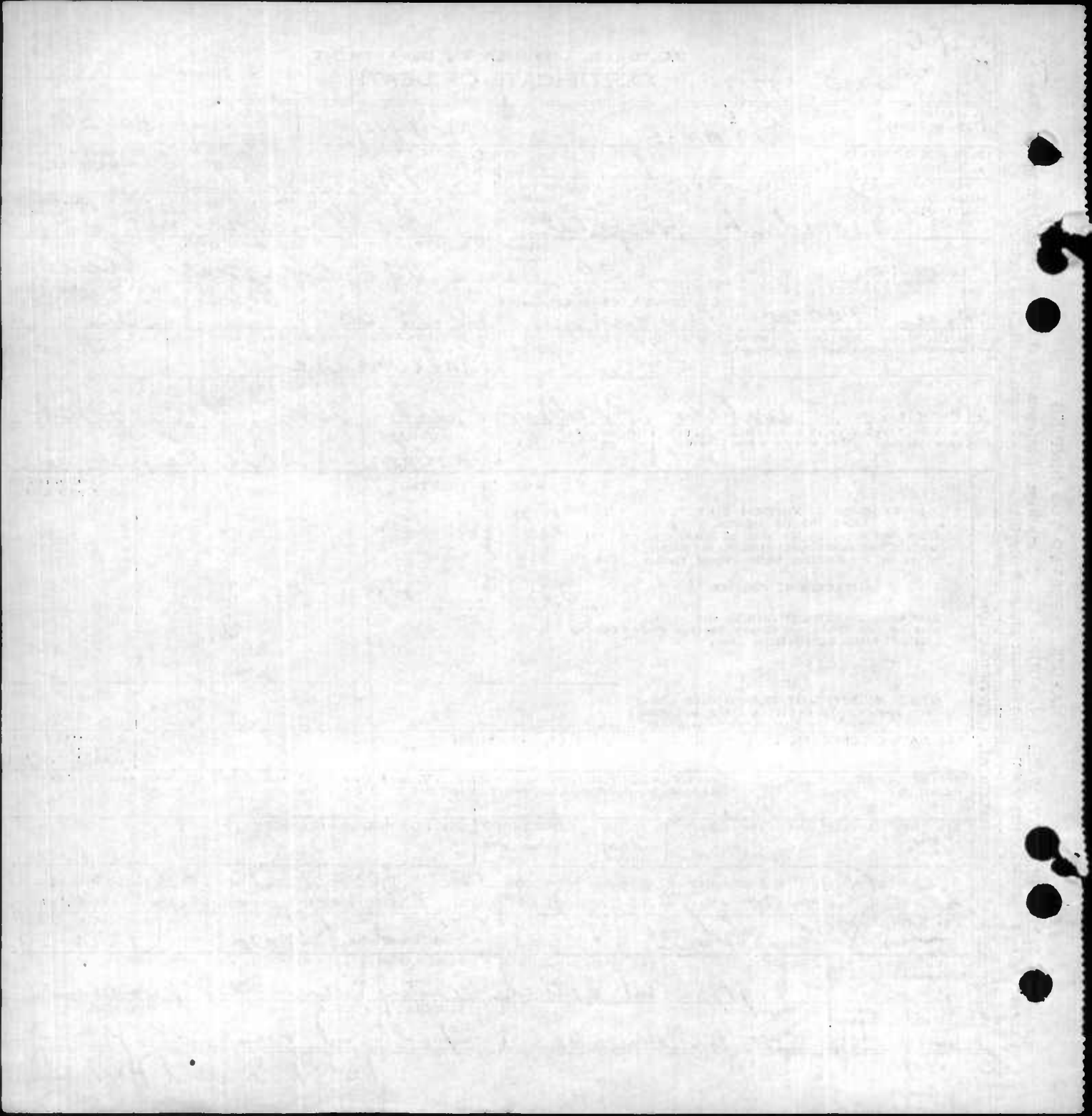
VS 150

*1831 Druid Hill Ave 119a*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 3994

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Olivia Lee Lettwich

2. DATE  
OF  
DEATH

4/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 14-03

D. STREET ADDRESS (If rural, give location)

2121 Madison Ave

c. Length of stay in Baltimore

55 Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3/7/50

9. AGE (In years  
last birthday)11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

1 24

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Oscar Melvin Lettwich

14. MOTHER'S MAIDEN NAME

Vertel Alice Lettwich

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, oo or oookooow)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother

2121 Madison Ave

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

CAUSE OF DEATH

Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Deformity of rt. knee - absence of patella, congenital  
and probably rt. fibula. (2) Right hip joint  
(3) Bony process extending from rt femur - Premature infant

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/7, 1950, to 4/28, 1950, that I last saw the  
deceased alive on 4/28, 1950, and that death occurred at 10:25 P. M., from the causes and on the date stated above.

23A. SIGNATURE

H. E. Welcome

M. D.

23B. ADDRESS

1106 Harlem ave.

23C. DATE SIGNED

5/1/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

May-1-1950

Mt. Auburn

Baltimore, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

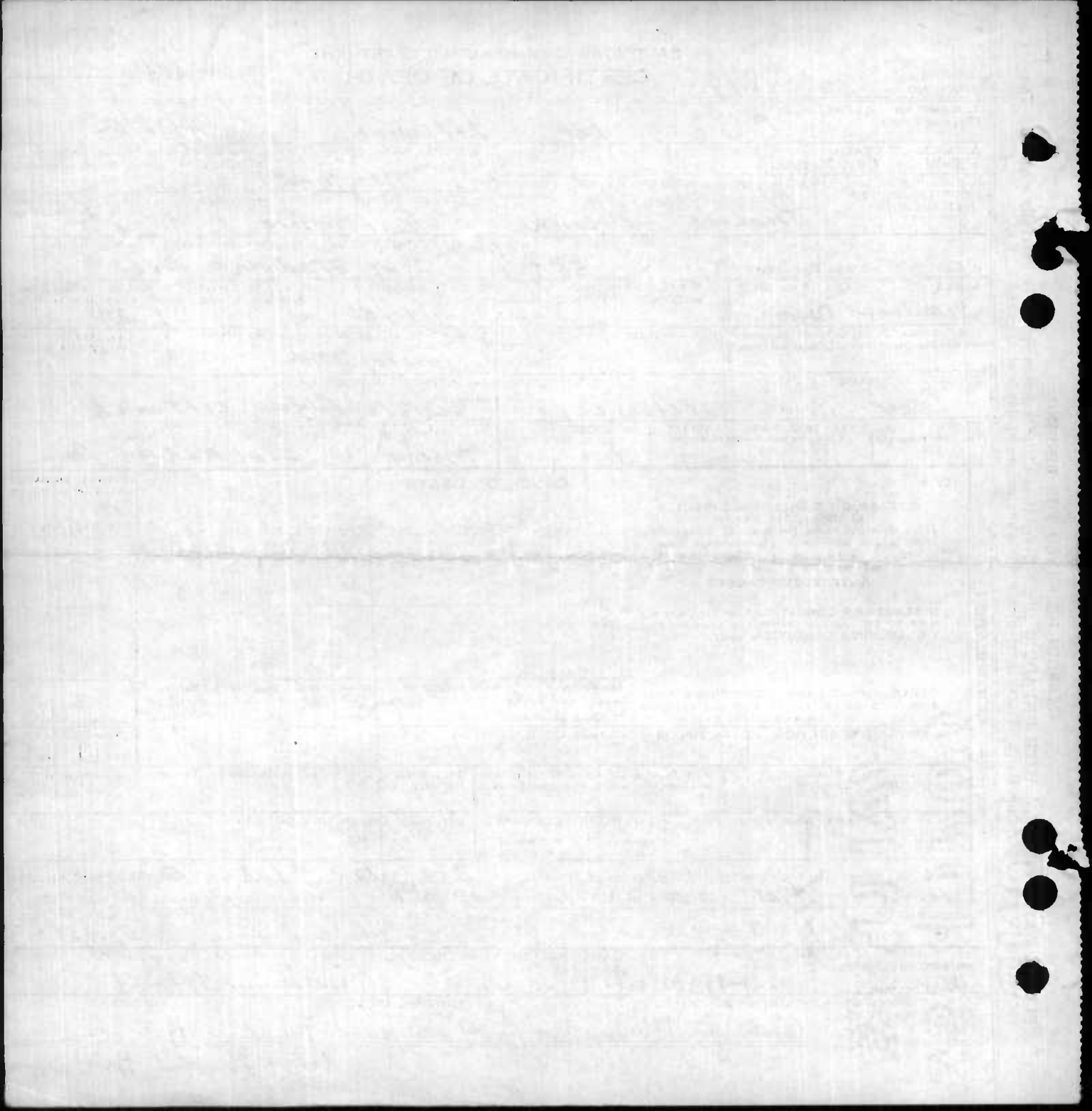
MAY 1 - 1950

Huntington Williams

Holland Funeral Home

1631 Druid Hill ave

83a



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LULA MARTIN

2. DATE  
OF  
DEATH

April 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

2446 Terra Firma Rd.

4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 25-02 H

D. STREET ADDRESS (If rural, give location)

2446 Terra Firma Rd.

c. Length of stay in Baltimore

23 yrs.

5. SEX

Female Colored

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 1, 1902

9. AGE (In years  
last birth day)

48

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Detroit, Mich

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

James Martin 2446 Terra Firma Rd.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Generalized arteriosclerosis Unknown

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Marasmus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8, 1950 to 4-29, 1950, that I last saw the  
deceased alive on 4-25, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

C. R. Campbell

M. D.

23B. ADDRESS

718 Dolphin St.

23C. DATE SIGNED

5-1-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

May 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

MAY 1 - 1950

REGISTRAR'S SIGNATURE

L. H. Williams, Jr.

25. FUNERAL DIRECTOR

Holland Funeral Home  
1651 Druid Hill Ave.

RECEIVED  
OFFICE OF THE  
DIRECTOR  
JAN 12 1964



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 3996  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		HARRY CHANEY		Apr. 29, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.		
B. FULL NAME OF HOSPITAL OR INSTITUTION 6 N. Hilton St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-07		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 6 N. Hilton St.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug. 3, 1894	9. AGE (In years last birthday) 55	If Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10B. KIND OF BUSINESS OR INDUSTRY retail jewelry	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward Chaney			14. MOTHER'S MAIDEN NAME Elizabeth Young		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. World War #1 212-09-1707	17. INFORMANT ADDRESS Mrs. Esther Chaney 6 N. Hilton St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Stomach Cancer Anemia Severe		INTERVAL BETWEEN ONSET AND DEATH Unknown 2 yrs
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr 1, 1949 to Apr 29, 1950 that I last saw the deceased alive on Apr 29, 1950, and that death occurred at 3 P. m., from the causes and on the date stated above.					
23A. SIGNATURE J. Mendelis M. D.		23B. ADDRESS 651 N. Beutalou		23C. DATE SIGNED 5/1/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/2/50		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR MAY 1 - 1950		REGISTRAR'S SIGNATURE Huntington Williams, Jr.		25. FUNERAL DIRECTOR ADDRESS Wm. J. Dickens & Sons Balt. Md.	



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

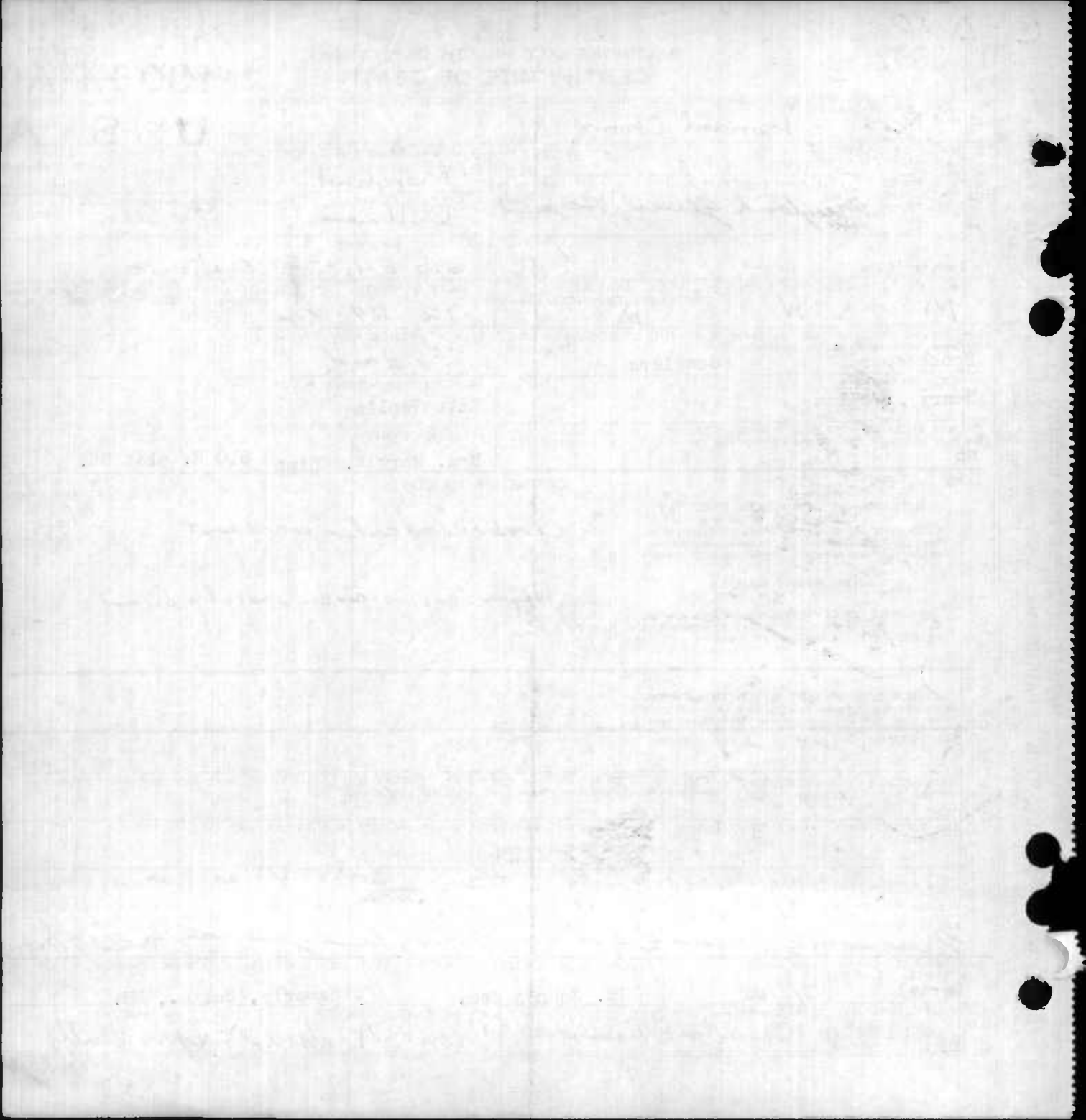
28. [Illegible]

29. [Illegible]

30. [Illegible]







BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. **50 3998**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lloyd

BOYKINS

2. DATE  
OF  
DEATH

April 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Franklin Square Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

12 N. Stricker St.

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

August 5, 1905

9. AGE (years last birthday)

44

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Franklin, Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Julius Boykins

14. MOTHER'S MAIDEN NAME

Mattie Powell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Geraldine Boykins, 12 N. Stricker St.

18.

443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease

DUE TO

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

April 29, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

6-2-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cem Balto.

24D. LOCATION (City, town or county) (State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

Miss Kate R. Williams

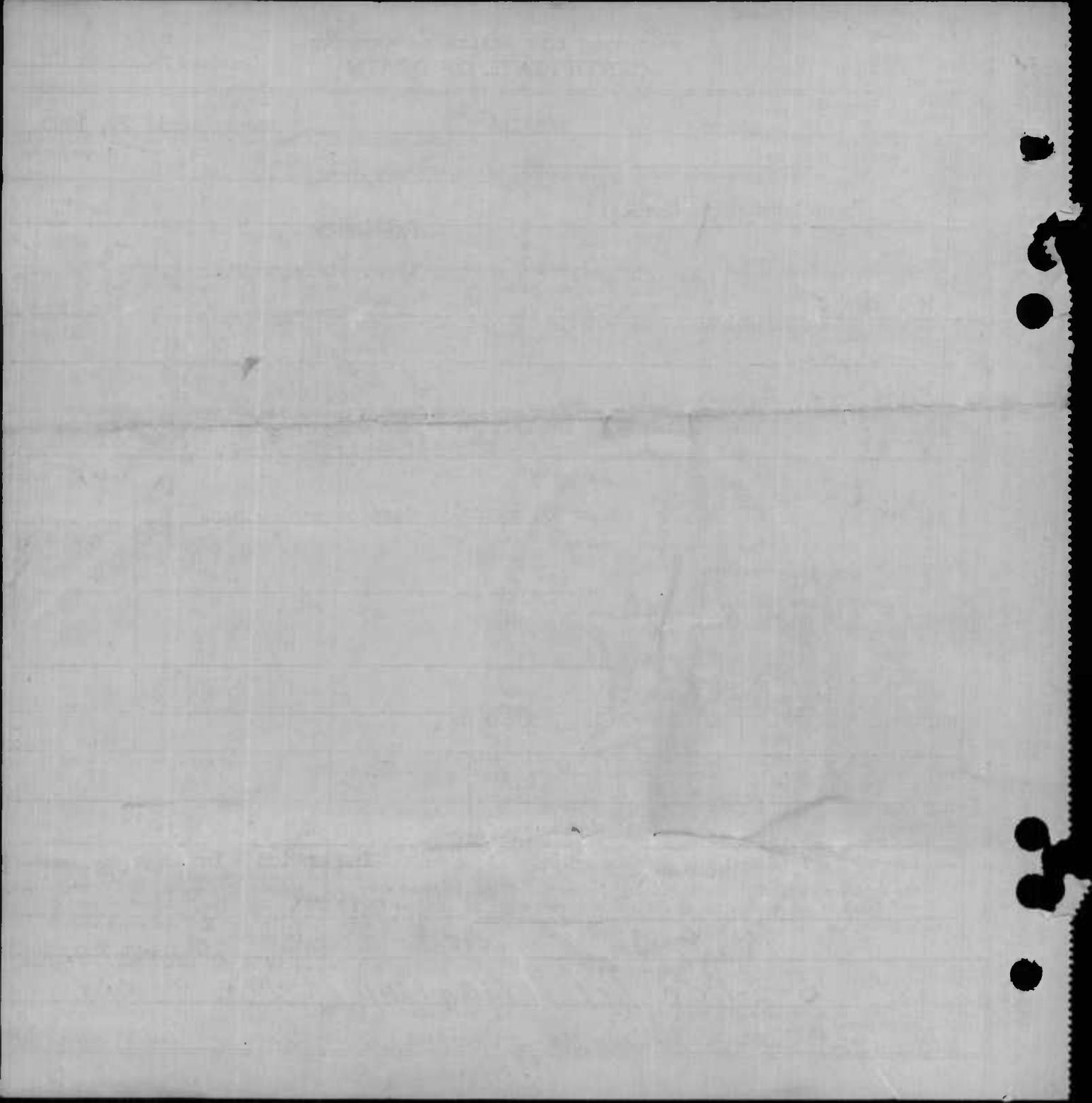
ADDRESS

322 N Schenck St

VS 151

98899

93D ✓



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 3999

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

Mr. Horney Taylor

2. DATE

OF DEATH 27-April, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Mercy Hospital*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Mercy Hospital Balto. 2-nd*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*2008 W. Payson St.*

C. Length of stay in Baltimore

?

Yrs.

Mos.

Days

5. SEX

*Male*

6. COLOR OR RACE

*Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*unmarried*

8. DATE OF BIRTH

*Oct. 1, 1896*

9. AGE (In years last birthday)

*53 54 yrs.*

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Farmer.*

10B. KIND OF BUSINESS OR INDUSTRY

*laborer*

11. BIRTHPLACE (State or foreign country)

*North Carolina*

12. CITIZEN OF WHAT COUNTRY?

*Yes. U.S.A.*

13. FATHER'S NAME

*Henry Taylor.*

14. MOTHER'S MAIDEN NAME

*Bettie ?*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*No*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Claron Taylor, 419 Mosher St.,*18. *177X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *Coronary Insufficiency 4-6 hrs.*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Metastatic Carcinoma 8-10 mos. over*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Prostatic gland Bilateral orchidectomy 10 yrs.*

19A. DATE OF OPERATION

*26 April 1950*

19B. MAJOR FINDINGS OF OPERATION

*none - apparent*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY, (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *25-Apr.*, 19*50*, to *27-Apr.*, 19*50*, that I last saw the deceased alive on *27-Apr.*, 19*50*; and that death occurred at *7:45 pm.*, from the causes and on the date stated above.

23A. SIGNATURE

*J. A. Williams*

M. D.

23B. ADDRESS

*Mercy Hospital*

23C. DATE SIGNED

*28-Apr-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*5-1-1950*

24C. NAME OF CEMETERY OR CREMATORY

*St. John Am. Landresses*

24D. LOCATION (City, town, or county) (State)

*Md.*

DATE RECEIVED BY LOCAL REGISTRAR

*MAY 1 - 1950*

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

*Mrs. Katie R. Williams*

ADDRESS

*Schroeder St.*

Prostate gland first organ involved. Letter in document  
file 50-3999 - 6/26/50.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 4000

Registered No. \_\_\_\_\_

BIRTH NO. 50-08025

1. NAME OF DECEASED (Type or Print) <u>HERBERT, Charles Joseph</u>			2. DATE OF DEATH <u>4-28-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <u>1012 Cameron Road.</u>		
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>newborn</u>	8. DATE OF BIRTH <u>4-16-50</u>		9. AGE (In years last birthday) <u>12 days</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Kenneth John Herbert</u>			14. MOTHER'S MAIDEN NAME <u>Thelma Maguire</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>K. J. Herbert</u>		
			ADDRESS <u>1012 Cameron Rd.</u>		

18. <u>7573</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Cyclonspirochitis</u>				<u>week</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congenital Deformity</u>				<u>12 days</u>	
19A. DATE OF OPERATION <u>no</u>		19B. MAJOR FINDINGS OF OPERATION <u>no</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>no</u>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u>		CHIEF OR ASST. MEDICAL EXAMINER <u>P. Fisher</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-28</u> , 19 <u>50</u> , to <u>4-28</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>4-28</u> , 19 <u>50</u> , and that death occurred at <u>4:15</u> Am., from the causes and on the date stated above.					
23A. SIGNATURE <u>William F. Stengel</u>		23B. ADDRESS <u>Union Memorial Hosp.</u>		23C. DATE SIGNED <u>4-28-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/1/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	24D. LOCATION (City, town, or county) (State) <u>Balt Md</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>MAY 1 - 1950</u>		REGISTRAR'S SIGNATURE <u>William F. Stengel</u>		25. FUNERAL DIRECTOR <u>L. J. Luck</u>	
				ADDRESS <u>5305 Harford Rd. 14</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The case with special importance. Physicians: please write the causes of death clearly and legibly.

